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ABSTRACT

Intended to foster program-to-program learning from within the Head Start community about how programs infuse a mental health perspective into Head Start, this report highlights strategies generated by seven Head Start programs to better meet the changing and intensifying mental health needs of Head Start children, families, and staff. The report is designed to stimulate dialogue about difficult issues that are often unaddressed, such as skepticism about traditional mental health strategies, the depth of need among some families, or where to find funding. An additional goal of the report is to spur communication and collaborative partnerships between the mental health, Head Start, and other service communities. Chapter 1 of the report summarizes the reasons that new attention to building nontraditional and strengthening traditional mental health strategies is both critical and possible. Chapter 2 presents mental health-related strategies that focus on staff development involving primarily work with children. Chapter 3 highlights new ways of engaging families, particularly those with the most complex stresses. Chapter 4 describes those few programs whose mental health-related strategies include strong connections to the larger community, either through collaborations around integrated services, or as part of community efforts to address problems such as substance abuse. Chapter 5 focuses on issues related to efforts to enhance mental health in the context of Head Start. These issues include assessment, gaps in research, financing needs, and the kind of training and technical assistance all programs need to enhance mental health-related strategies. Chapter 6 summarizes the lessons learned and offers recommendations at the program, community, state, and national levels. (Appendices contain a list of resources, national organizations concerned with children's mental health, Head Start mental health performance standards, and program and resource contacts cited in lessons from the field). (JPB)

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LESSONS FROM THE FIELD

Head Start Mental Health Strategies to Meet Changing Needs

Hirokazu Yoshikawa
Jane Knitzer

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AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

LESSONS FROM THE FIELD

Head Start Mental Health Strategies to Meet Changing Needs

Hirokazu Yoshikawa
Jane Knitzer

A joint publication of the

National Center for Children in Poverty
Columbia School of Public Health

and the

American Orthopsychiatric Association
Task Force on Head Start and Mental Health

National Center for Children in Poverty (NCCP) was established in 1989 at the School of Public Health, Columbia University, with core support from the Ford Foundation and the Carnegie Corporation of New York. The Center's mission is to identify and promote strategies that reduce the number of young children living in poverty in the United States, and that improve the life chances of the millions of children under age six who are growing up poor.

The Center:

- Alerts the public to demographic statistics about child poverty and to the scientific research on the serious impact of poverty on young children, their families, and their communities.
- Designs and conducts field-based studies to identify programs, policies, and practices that work best for young children and their families living in poverty.
- Disseminates information about early childhood care and education, child health, and family and community support to government officials, private organizations, and child advocates, and provides a state and local perspective on relevant national issues.
- Brings together public and private groups to assess the efficacy of current and potential strategies to lower the young child poverty rate and to improve the well-being of young children in poverty, their families, and their communities.
- Challenges policymakers and opinion leaders to help ameliorate the adverse consequences of poverty on young children.

The American Orthopsychiatric Association (Ortho) is an interdisciplinary organization that provides a common meeting ground for collaborative study, research, and knowledge exchange among individuals from a variety of disciplines engaged in preventive, treatment, and advocacy approaches to mental health.

Ortho fosters development of theory, practice, and social action from integrated as well as distinct psychological, biological, social, and cultural perspectives. It facilitates a shared commitment to scholarship and clinical expertise in the interest of informing professional practice and public policy.

Hirokazu Yoshikawa is a Ph.D. candidate in clinical psychology at New York University. He was also the project coordinator for the Task Force on Head Start and Mental Health of the American Orthopsychiatric Association.

Dr. Jane Knitzer, who chaired the Task Force, is the deputy director of the National Center for Children in Poverty.

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Copies of *Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs* are available prepaid for $9.95 for Head Start and child care programs, $15.95 for all others, from the National Center for Children in Poverty, Columbia School of Public Health, 154 Haven Avenue, New York, NY 10032; Tel: (212) 304-7100; Fax: (212) 544-4200. Checks should be made payable to Columbia University.

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"One kid—he was so aggressive. He would come in and the first thing in the morning he'd be throwing cups of water at other kids. Kicking and yelling all the time. It got so the other kids wouldn't play with him at all. It took a lot of work. A lot of times I'd talk to him one-on-one, talking about why he was so angry. He'd say, "Because no one wants to be friends." I'd suggest that it may be because you hit so-and-so. Now he's made friends with the other children. He's learned to communicate how he feels. Peers really see the change; when he uses the words, "This bothers me," then they respond. And the training helped—it really motivated me to keep working with him. By April, there was a really big change in him."

—Head Start teacher who had been through the Choosing Non-Violence staff training of Rainbow House, Chicago, Illinois

"I think the mental health parent group is great. Being a single parent, I have really been able to learn a lot from the group leaders and from other people. I have learned a lot about children's feelings and behaviors. I have been able to take what I have learned and use it with my four-year-old. I have been able to adapt it to use with my other boys too.... I am much more self-confident about working with my children. We are able to share more. They have learned to express their feelings and so have I."

—Head Start parent who participated in one of the mental health parent groups at Ulster County Community Action Program Head Start, New York

"When I first began as a consultant, I felt I wasn't doing anything unless I could find fault with everything I set my eyes upon. Now I know that the formula for empowerment is supportive relationships with staff, which stimulate supportive relationships with parents, who in turn have more to give to their children."

—Mental Health Consultant Barry Litt, "Head Start and MFT: Tools for Empowerment," *Family Therapy News*, October 1993.

Acknowledgments

We are indebted to many people for their assistance with *Lessons from the Field*.

Edward Zigler, a cofounder of Head Start, first suggested that there be a Task Force on Head Start and Mental Health during his presidency of the American Orthopsychiatric Association. We thank him for his long-standing vision and leadership. We are also grateful to the members of the Task Force on Head Start and Mental Health who helped provide a sound framework for this follow-up effort.

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Most importantly, we are indebted to the parents, directors, mental health coordinators and consultants, family advocates and other family service staff, teachers, and members of Head Start and the mental health community who shared their personal stories, their insights, and their challenges about mental health in the context of Head Start.

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This report is dedicated to the Head Start staff who care so much about their children and families, and to the families themselves, who each day face the challenges of poverty with strength and resilience.

Preface

It has taken a very long time to give mental health goals a meaningful place in the national Head Start agenda. For many of us who were present at the beginning of the great national experiment of Head Start, securing a sound mental health foundation for all Head Start children has always been of critical importance. From the first, there was the recognition that healthy development of the emotional, social, and motivational aspects of a child's being were central to the capacity to succeed in school and to grow into a well-integrated adult. Nevertheless, translation of this concern into concrete programs within Head Start has been difficult. There are a number of reasons for the difficulty, including lack of funding and the concomitant lack of adequate technical assistance for mental health services, lack of agreement as to what preventive or therapeutic strategies are appropriate and effective among Head Start families, and a lack of research findings connecting existing services with outcomes. Thus only now, three decades down the road, are we preparing to replace inconsistent, fragmented, and poorly evaluated mental health strategies with unified effort and systematic action. These efforts come not a moment too soon.

Today's families are facing unprecedented levels of stress from many sources, most of which particularly threaten Head Start families and children. Community violence, crime, child abuse and neglect, teenage pregnancy, health threats such as HIV/AIDS and lack of adequate health care, and the negative effects of family dysfunction and divorce are all present in the society at large, but these factors tend to cluster in increasingly dangerous combinations in the lives of families in poverty. These problems, seemingly diverse, have one thing in common: All are serious threats to mental health. Head Start programs find themselves on the front lines in many communities, facing virtually all social problems at once in the effort to serve their member families. We need mental health strategies not only for children and parents, but for preserving the well-being of staff as well.

In the thick of this battle for the lives of children, a number of Head Start programs have emerged as particularly valiant and resourceful leaders. This volume documents the efforts of 14 such programs. *Lessons from the Field*, an outgrowth of the Task Force on Head Start and Mental Health of the American Orthopsychiatric Association, is the culmination of two years of careful work on the part of two esteemed and insightful colleagues, Hiro Yoshikawa and Jane Knitzer. Their excellent ground-breaking report allows us to learn from the best of current Head Start practice in order to construct what I believe will one day become a system of effective, nonstigmatizing, and family-focused interventions that will help Head Start families and children acquire the coping skills they need to better manage the stressors in their environment, while also safeguarding the mental health of Head Start staff and administrators.

In these days of increasing poverty and social decay for many families, it has become very difficult to begin any account of the conditions under which impoverished children live without a certain note of despair for their future emotional well-being. However, Yoshikawa and Knitzer have provided in their fine book a beacon for those of us who believe strongly in the efficacy of preventive mental health services and in the possibility of designing a more focused mental health component for Head Start. It is long past time for us to renew our efforts in this direction, and I am grateful to these authors for bringing together these excellent pathways, which can provide the foundation for constructing an effective nationwide Head Start mental health initiative.

Edward Zigler, Ph.D.
Yale University
New Haven, 1996

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Executive Summary

Lessons from the Field: Head Start Mental Health Strategies to Meet Changing Needs highlights promising strategies generated by Head Start programs to better meet the changing and intensifying mental health needs of Head Start children, families, and staff. It is intended to foster program-to-program learning from within the Head Start community about how programs infuse a mental health perspective into Head Start. It is also designed to stimulate an open dialogue about difficult issues that are often unaddressed, such as skepticism about traditional mental health strategies, or the depth of need among some Head Start families, or where to find funding. Finally, *Lessons from the Field* is intended to spur communication and collaborative partnerships between the mental health and the Head Start communities, as well as others such as family support programs or substance abuse providers working with low-income families with complex needs.

Lessons from the Field is an outgrowth of the work of the Task Force on Head Start and Mental Health, which was convened in 1994 at the request of Edward Zigler, then president of the American Orthopsychiatric Association and a founder of and long time advocate for Head Start. The Task Force, chaired by Jane Knitzer, issued a report entitled *Strengthening Mental Health in Head Start: Pathways to Quality Improvement.* This publication explicitly called attention to the mental health-related challenges that the Head Start community is facing, the lack of information about how the field is coping with these challenges, and the inadequacy of the training and technical assistance related to mental health issues from either the larger Head Start or mental health communities.[1]

The focus of *Lessons from the Field* is on how Head Start programs are coping with the mental health-related challenges they face. The Executive Summary highlights the framework that guided the research, the data gathering strategies, and the findings. It includes a summary of program and fiscal mental health strategies identified, as well as the lessons learned and their implications for policy, practice, and research. Chapter 1 summarizes the reasons that new attention to building nontraditional and strengthening traditional mental health strategies in Head Start is both critical and possible. Chapter 2 presents mental health-related strategies that focus on staff development involving primarily work with children. Chapter 3 highlights mental health-related strategies that focus on new ways of engaging families, particularly those with the most complex constellation of stresses. Chapter 4 describes those few programs whose mental health-related strategies include strong connections to the larger community, either through collaborations around integrated services, or as part of community efforts to address problems such as substance abuse. Chapter 5 focuses on issues that are integrally related to efforts to enhance mental health in the context of Head Start. These include assessment, gaps in research, financing needs, and the

kind of training and technical assistance all programs need to enhance mental health-related strategies. Chapter 6 summarizes the lessons learned, as well as recommendations and implications for the future, at the program, community, state, and national levels. Throughout the report we use boxes to provide details on how a strategy works, on topics of practical interest, or on how strategies have affected particular children and families.

The Rationale for Greater Attention to Mental Health in Head Start

Philosophically, since Head Start began, it has maintained a commitment to mental health as an integral part of a child development orientation. In this context, mental health is defined broadly as promoting the healthy emotional development of children, supporting family strengths, identifying early signs of emotional and behavioral difficulties, and assisting families with special needs. Translating this vision into practice, however, has been problematic throughout Head Start's history.[2] This has been so for reasons which are as relevant today as in the 1970's.

- Mental health services are defined narrowly as therapy, either for children or families. Yet there is great skepticism about how effective such therapy is for Head Start children and families.
- There is a reluctance to label more troubled children as having emotional or behavioral problems.
- There has not been a well developed system for providing the Head Start community with technical assistance around how to implement responsive mental health strategies.
- Research has not highlighted the impact that different approaches to infusing a mental health perspective in Head Start have on outcomes for children, families, staff, or on program quality as a whole.
- It has been difficult for Head Start program directors and others to find, or pay for, mental health consultants who have expertise in working with young children and/or low-income families.

While these realities have been constant throughout Head Start's history, four sets of reasons make this an important time to escalate the dialogue at the community, state, and national levels about the role of mental health in Head Start.

Increased Stress

The first set of reasons has to do with the level of stress and need among Head Start children, families, and staff:

- Staff report that children are showing more and more evidence of stress in the classroom, with a significant number exhibiting withdrawn, aggressive or "out of control" behaviors that challenge the staff and sometimes threaten the overall classroom climate.
- A significant proportion of families with children in Head Start have intense and complex needs. Community and family stresses such as substance

abuse, domestic violence, HIV/AIDS, unemployment, depression, and community violence combine for many parents in ways that affect their ability to engage with their children and with Head Start programs.

- Head Start staff, too, must cope with difficult stresses. For some, there is burnout related to the depth of need that they see. Others are coping with difficult realities in their own lives not unlike those facing the Head Start parents and children.
- As Head Start becomes increasingly multi-ethnic, staff face enormous challenges in not only finding creative ways to strengthen respect for the different cultural backgrounds reflected in the children and families, but also in resolving work-related cross cultural conflicts (such as the tensions reflected in different expectations about child rearing and discipline).
- Children with serious emotional and behavioral problems appear to be under identified in Head Start. Program Information Reports from the 1994–1995 year suggest that only two-thirds of one percent of Head Start children are identified as having such disorders. But careful studies have estimated that a much larger percentage of the children could benefit from some form of planful intervention.

New Developments in Children's Mental Health

The second set of reasons for reemphasizing the role of mental health in Head Start has to do with new developments in children's mental health which have resulted in the creation of "systems of care" to serve largely older, troubled children and adolescents. These systems of care are characterized by:

- A commitment to family-centered mental health and related services, with parents as partners in the decision-making and treatment process for their own children, as well as participants in larger governance strategies.
- A belief that children, even those with emotional and behavioral difficulties, should have as many opportunities as possible to participate in age appropriate activities in normal settings, with whatever supports are necessary.
- A commitment to use mental health dollars flexibly to respond to what families need, not just what mental health providers have traditionally offered (outpatient treatment, day treatment or placement in residential settings). Thus, mental health dollars have been used for home- and school-based services, including intensive in-home therapies, respite care, mentors, and coaches. This fiscal flexibility supports clinical flexibility in responding to family needs.
- A recognition that mental health services alone, without the support of other agencies, rarely works. This has led to efforts to work collaboratively with other community agencies, including the schools, child welfare agencies, and the early childhood community, on behalf of children with behavioral and emotional problems.

These four tenets are parallel to the core Head Start philosophy—a commitment to parent involvement; a belief in the power of integrating

children with special needs in Head Start settings, a flexible approach to services, and a recognition of the importance of working with other community agencies and leaders, offering new opportunities for collaboration at the program and training level. However, to date, there has been only a limited effort to expand system-of-care concepts to Head Start, and many in the Head Start community are unaware of these new developments. This appears to be changing, with new interest in early intervention and prevention reflected in community-based mental health initiatives on behalf of young children and families.[3]

New Opportunities in Head Start

The third cluster of reasons to focus new attention on mental health in the context of Head Start has to do with renewed interest from the Head Start community in addressing issues of quality. This includes a greater focus on the role of mental health within the context of Head Start, illustrated by the attention paid to mental health in the newly promulgated Head Start Performance Standards.[4] Unlike previous standards, these emphasize the importance of having a mental health consultant on-site frequently enough to build a relationship with staff and families. Such standards provide the necessary (although not sufficient) context to encourage the development of more effective mental health strategies, particularly in the face of increased family stresses.

Lessons from Research

A growing body of child- and family-related research indicates that intervening in the lives of at-risk children can help reduce the level of later problems, such as school dropout or delinquency. The key to successful interventions seems to be intensity and quality of services, as well as attention to *both* family and child. By offering intensive services to both parents and children, these programs seem to have affected a range of family and child delinquency risk factors, as well as antisocial behaviors and delinquency itself. Strengthening mental health supports to children, families, and staff is one way of enhancing the intensity of support offered to children and families, and hence its potential impact.

For these reasons, then—the urgency of the need, the emergence of a new children's mental health orientation consistent with the Head Start philosophy, new interest from the mental health community in prevention and early intervention, recognition from within Head Start about the need to focus on mental health—*Lessons from the Field* offers insights upon which to build new directions and initiatives, both for the Head Start community and for the larger early childhood community.

The Questions and Assumptions that Guided *Lessons from the Field*

Based on the review of the literature and the work of the Task Force, eight questions guided oureffort to emphasize deliberate, goal-oriented strategies.

- How can planning within Head Start and with other community agencies be a tool to infuse a mental health perspective throughout the program?
- What strategies are programs using to enhance teacher skills in working with children whose behaviors are troublesome, or frustrating? Children with other special needs? Crisis situations?
- What strategies are programs using to enhance the skills of family support/service staff and home visitors?
- What strategies have programs found effective in engaging families with different combinations of strengths and needs?
- How do programs work directly with individual children experiencing difficulty? With families experiencing multiple stressors?
- In what ways do programs ensure that mental health consultants are integrated into the Head Start program?
- What kinds of services are appropriate for young children exhibiting seriously troubled behaviors?
- How is it possible to pay for the kind of mental health services that seem to make sense when most mental health dollars are only for traditional treatment?

How the Information was Gathered

Lessons from the Field used three strategies to identify the programs described. First, we encouraged self-nominations from Head Start programs, placing a call in the National Head Start Association Journal, which is sent to all Head Start programs. In addition, we sent out mailings to solicit names of programs from key informants, including leaders in the Head Start community, regional office staff, and members of the Task Force on Head Start and Mental Health of the American Orthopsychiatric Association. Finally, we attended conferences such as the annual meeting of the National Head Start Association to identify programs engaged in improving mental health and family support.

This resulted in the identification of 73 programs, partnerships, and initiatives within Head Start, including programs which referred themselves. Staff at all of these programs were contacted, either by phone or through site visits. Information was gathered on: (1) the nature of the program and its focus on mental health; (2) the geographic location and community served, including suburban, urban, and rural areas, number of families served, and cultural and ethnic backgrounds of families served; (3) the history of the initiative, including first impetus, development of collaborations, if any, funding strategies, initial efforts and how they subsequently developed or were revised; (4) the impact of the initiative on staff, parents, and children.

In the second stage of the project, we reviewed the information on the 73 programs to winnow them down to a more manageable group. Fourteen programs which best illustrated general strategies and approaches to improving mental health in Head Start, and which represented a diversity of geographic areas and populations served were chosen for more in-depth interviews and site visits. A variety of key informants were contacted at these

programs, including Head Start staff, administration, parents, and key members of other participating agencies (such as local mental health agencies). Of the 14 programs, 7 were visited. Information gathered included in-depth data on the issues explored in the initial scan, as well as vignettes illustrating each program's effects on Head Start children, parents, and/or staff. (Several additional programs are briefly mentioned in sidebars.)

All of the final program descriptions were reviewed by the programs. (In some instances, we removed identifying details about staff or families.) In addition, a draft of the entire report was shared with members of the Head Start community and of the Task Force for review.

How the Report Can Be Used

This report is intended to be useful to program directors who have to use scarce monies to meet mental health requirements, and to mental health coordinators and consultants as they grapple with how best to use limited time and gain the most impact. But the report also has implications for those at the state and national levels. It is particularly relevant to those developing strategies to help the field implement the revised performance standards that provide a new emphasis on mental health. We hope, too, that the report will be useful to those administering the Head Start State Collaborations (now in almost all the states), and especially to Head Start, mental health organizations, family support providers, and others involved in the increasingly collaborative community-based efforts to build integrated systems of care for young children and families.[5] Finally, we believe the report has implications for researchers who have long ignored, but seem to be increasingly recognizing, the importance of the mental health aspect of the Head Start program and the significance of behavioral and emotional well-being of young children for future school success.[6]

The Key Findings

The 14 Head Start programs profiled in this report engage in mental health strategies that focus on staff development, on families, and, to a lesser extent, on community-level collaborations. Most use mental health consultants to facilitate the development of a coherent approach to the children and the families, and to help staff develop more mental health-related skills, as well providing more traditional services. Across the programs the following themes emerged.

- Staff support and skill development related to mental health can take many forms. Programs are using strategies ranging from classroom mentoring and coaching, to supervision enriched with a mental health perspective, to access to career ladders and community credentialling programs, to peer support for those working with difficult-to-engage families.
- Directors and mental health coordinators report that staff support and mental health-related skill development pay off in multiple ways: better problem solving skills, greater staff confidence in coping with difficult situations, a wider range of concrete strategies to help children and families, and the provision of a safety valve which enables staff to share the frustrations as

well as celebrate the victories of their work. All of these factors can help create and sustain the kind of caring culture that is the hallmark of Head Start.

- For families, on-site, family supportive, non-stigmatizing services are less threatening than the usual referral for therapy. Parent groups, for example, help families feel more comfortable talking about problems, asking for help, and seeing strengths. Sometimes this is enough. Sometimes, it makes families more willing to accept traditional mental health services if they need them. Linking parents with family support programs can occur either by bringing family support programs on-site, or by building parent-to-parent support within Head Start.
- Mental health strategies in Head Start work best if they are tailored to community and cultural meanings of mental health. Sensitivity to the particular attitudes, strengths, and resistances to mental health which may be present in a community requires a willingness to revise and adopt strategies that best fit the families served by the Head Start program.
- Infusing a program with family-focused mental health strategies requires a shared vision that takes time to develop. It may also require a shift in how staff perceive families' strengths and what their lives involve. Programs report that mental health strategies that start by responding to family concerns pay off, but that using strength-based, family-centered service strategies requires significant staff- and director-level support.
- Effective family-focused mental health strategies in Head Start involve all staff crossing sometimes rigid component boundaries among mental health, social services, and parent involvement.
- Organizing communities to address problems can be an effective component of Head Start's efforts to deal with seriously troubled children and/or families with severe challenges, such as substance abuse. However, although 6 of the 14 programs report collaborations with local community mental health centers, only two of the programs report serving the most seriously troubled children using community-based system-of-care principles. Only one reported using community organizing as a strategy to complement more direct work with substance-abusing families (and that as a result of a foundation-supported initiative).
- Implementing a holistic and deliberate mental health strategy that goes beyond observations and referrals takes time. In many cases the process starts with trial and error, and then evolves into an approach that fits the needs of the programs. Fiscal creativity is often required, such as maximizing Medicaid, pooling Head Start dollars across components, or using quality improvement funds.
- There is woefully little evaluation to guide the choice of one mental health-related strategy over another, or even to help program directors and management staff envision the potential strategies. The choice is often a matter of chance, based on what approaches and/or resources a particular program can access. Anecdotally, many programs reported increased parent involvement, or improved classroom environment as staff competence in meeting the needs of challenging children or helping families address complex issues increased. Empirically, however, there is little data to guide the field.

Six Lessons from the Field: The Message at a Glance

- Focusing on the strengths of children and families is core to the Head Start philosophy, but is sometimes hard to do, especially when families have complex needs, or children engage in provocative behaviors.
- Often the most effective ways of helping young children are indirect; for example, having mental health consultants work with the teachers or parents to change their perspectives or approaches to the child, rather than working directly with the child.
- Often the most effective way of engaging parents stressed by chronic poverty, violence, depression, or substance abuse is to start where they are, helping them to address whatever is most important to them—even if it is not child-related. Offering child-focused mental health services in a vacuum often does not work.
- Paying strategic, deliberate attention to the emotional and behavioral issues facing children, families, and staff is crucial to having a quality Head Start program.
- Ongoing, trusting relationships among consultants (or staff members) with mental health expertise, staff, and families are critical. The mental health consultant must be a familiar part of the program.
- Children who do exhibit serious emotional and behavioral disabilities should be linked with system-of-care efforts through mental health agencies that include both families and Head Start as critical partners in the treatment effort.

What Mental Health Means in the Context of Head Start

Mental health strategies cited in this report share five characteristics. They are:

- *Focused on family and staff, as well as on children,* in recognition that healthy adult-child, as well as peer relationships are a key foundation for social and emotional competence in young children;
- *Strength-based,* with a philosophical value orientation toward identifying strengths, as well as challenges facing families and individual children
- *Practical,* with an intent to embed a mental health perspective into the day-to-day challenges Head Start families face (e.g., helping homeless families deal with the transition to kindergarten; preparing parents for meetings with managed care providers);
- *Clinically and culturally sensitive,* grounded in understandings of the complexities of need, stress, and behaviors as they affect families from diverse cultural backgrounds (e.g., encouraging cultural expression in a parent support group for African American mothers);
- *Open to new kinds of partnerships:* (for example, including parents in staff trainings; working with supervised interns from mental health agencies); and
- *Realistic about the need for deliberate strategies to make mental health "user friendly"* (for example, calling mental health consultants "early interventionists," providing on-site services to families in a familiar setting, using parent support groups to help engage families; addressing the fear that mental health is only for those who are crazy or is irrelevant to the lives of families who day-to-day struggle with urgent survival issues).

Where to Find It: A Guide to Mental Health Program and Fiscal Strategies Highlighted in *Lessons from the Field*

To develop an overall approach to mental health, mental health coordinators and program directors or delegate agency directors report:

- Creating an interagency planning committee focused on mental health that includes key leaders from the community, e.g., parents, school superintendent, chair of mental health board, outreach director for health and mental health managed care organizations serving the community (Ulster County, Chapter 3).
- Using the mental health subcommittee of the Health Advisory Committee (Ulster County, Chapter 3).
- Participating in community-wide collaborations to plan for and integrate services for young children and their families through family resource centers, and service integration efforts (Hawkeye Area Head Start, Chapters 3 and 4).
- Carrying out internal assessments with program staff and families (many programs).

To enhance mental health-related competencies in Head Start staff, mental health consultants collaborate with staff by:

- Offering in-classroom coaching and mentoring (Nassau County, Chapter 2).
- Facilitating teacher support groups (Nassau County, Chapter 2).
- Participating in and being a consultant to routine staff meetings (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Facilitating group consultation and support to home visitors and/or family service workers (Rosemount Head Start, Chapter 2).
- Facilitating peer support meetings with family service workers (Head Start Parent Involvement Project, Chapter 3).
- Facilitating classroom or cross-component team meetings (Hawkeye Area Head Start, Chapter 3).
- Providing individual consultation to the director and staff (Nassau County, Chapter 2, and many of the other programs).
- For programs with multiple sites and multiple consultants, convening a network of mental health consultants and providing periodic support meetings (Action for Boston Community Development, Chapter 3).

To help individual children in the classroom, mental health consultants in Head Start are collaborating with staff by:

- Using teacher-friendly, validated screening for children's emotional and behavioral development as a tool to help teachers as well as children (Early Screening Project, Chapter 5; Ventura County, Chapter 5).
- Providing one-on-one in-classroom consultation on specific children, problem-solving with teachers to develop interventions (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Helping to implement classroom prevention strategies (Choosing Non-Violence, Chapter 2; Management and Prevention Project, Chapter 2).
- Working with teachers to integrate mental health into classroom curricula, e.g., using stories to discuss such difficult issues as violence and grief (St. Bernard's, Choosing Non-Violence, Chapter 2).
- Using specially trained volunteer students to work with individual children (Jumpstart, Chapter 2).

To enhance strategies to engage and help families, Head Start staff and mental health consultants are:

- Helping staff examine their assumptions about families, enhancing their skills in identifying and building on family and cultural strengths (Nassau County, Chapter 2; Resiliency Partnership-Directed Intervention, sidebar in Chapter 3; Hawkeye Area Head Start, other programs as well).

- Identifying mentor parents, who provide extra support to isolated, hard-to-engage, or stressed parents (Hawkeye Area Head Start, Chapter 3; Resiliency Project, sidebar in Chapter 3; Free to Grow and Community Partnership for Child Development (CPCD) Head Start, Chapter 4).
- Helping families create a resource exchange to share skills (Hawkeye Area Head Start, Chapter 3).
- Using staff and mental health consultants to enhance parenting skills in a family friendly way (Partners Parent Training, sidebar, Chapter 3).
- Using parent support groups to enable parents to discuss issues of most concern to them at their own pace. Remaining on the alert for serious problems (e.g., clinical depression, suicidal behaviors) (Ulster County, Chapter 3; Resiliency Project, sidebar in Chapter 3).
- Helping families with the transition to school, especially when parents own school history has not been positive, e.g. rehearse parent-teacher conferences (St. Bernard's, Chapter 2).
- Opening staff training sessions on mental health-related topics to parents and other caregivers (many of the programs).
- Developing targeted strategies for specific groups of families, e.g., hard-to-engage families or families involved with substance abuse (Head Start Parent Involvement Project, Chapter 3; Resiliency Project, Chapter 3, sidebar; Free to Grow and CPCD Head Start, Chapter 4).
- Providing families of children showing serious behavioral or emotional problems with access to nontraditional mental health services, such as respite care or in-home therapy (Stark County, Chapter 4).

To expand training opportunities related to mental health, Head Start programs are:

- Providing Head Start as a training site for social work and psychology interns. (Supervision can be provided either by the Head Start program, if necessary hiring a qualified supervisor with Head Start funds, or by a local mental health center or other approved training site (Ulster County, Chapter 3).
- Providing Family Development Certification courses for Head Start staff (Hawkeye Area Head Start, Chapter 3).
- Building career ladders for staff interested in family support and mental health, working with local community colleges or other training institutions (Action for Boston Community Development (ABCD), Chapter 3).
- Developing courses in conjunction with local community colleges in family support/mental health (ABCD, Chapter 3).

To maximize dollars and resources for mental health-related activities, Head Start programs are:

- Collaborating with mental health centers to maximize the use of Medicaid dollars (Ventura County, Chapter 5).
- Networking with managed health and mental health care providers (St. Bernard's, Chapter 2; ABCD, Chapter 3).
- Developing jointly-funded projects with local community mental health and family support agencies (Nassau County, Chapter 2; St. Bernard's, Chapter 2; Stark County, Chapter 4; Ventura County, Chapter 5).
- Encouraging states to facilitate Head Start/Medicaid collaborations (sidebar on state-level Head Start/Medicaid collaborations in Chapter 5).
- Working with children's mental health advocates to increase mental health dollars targeted for early childhood mental health initiatives (Stark County, Chapter 5).
- Pooling Head Start funds to hire mental health professionals (ABCD, Chapter 2).
- Using volunteer mental health professionals (Rosemount, Chapter 2).
- Using well-supervised psychology and social work interns (Ulster County, Chapter 3).

Lessons and Recommendations

Lessons from the Field has three central messages:

1) Many Head Start programs take a very narrow view of mental health, (partially to comply with current requirements, partially by default), which does not really meet the needs of the staff, the families, or the children. The goal of the programs highlighted here is to create a holistic vision in which mental health strategies work in the service of staff, families, and children in a coherent manner.
2) Embedding new approaches to mental health in the context of Head Start is difficult. There are no quick fixes or even quick answers to enhancing the capacity of Head Start to better support the emotional and behavioral well-being of families and children living with many risks and stressors. None of the programs described is fully satisfied with where they are; all are in process, and all have faced many bumps and challenges along the way in terms of finding the right people, the right approach, and stable funding.
3) Despite the important work of the programs we learned about over the course of this study, and no doubt many others that we did not identify, well-developed mental health strategies that can enhance the success of Head Start programs are now too limited, too unevaluated, and too unsupported with training and technical assistance.

The recommendations below frame an action agenda to meet the challenges set forth in this report.

What Can Be Done at the Head Start Program and Community Level

Integrate a mental health perspective into all parts of the Head Start program.

- Move from an "on-call" to an "on-site" role for the consultant.
- Expand the consultant's role to include home visits and participation in staff and management meetings and staff-development activities.
- Integrate the mental health/family support perspective into all activities of the program.
- Use planning strategies to help Head Start directors and management teams envision and develop strategic mental health approaches that strengthen the quality of the program and the capacity of each program to respond to the level of stress among Head Start children and families.

Empower and support staff while building their mental health expertise.

- Involve the consultant in regular management and/or cross-component meetings and activities.
- Support the well-being of staff.
- Encourage and facilitate opportunities for staff to explore cultural and ethnic differences, including those regarding discipline, in ways respectful of families and Head Start staff.
- Ensure that training curricula related to mental health competencies are not "one-shot" workshops, but provide ongoing support.

- Develop career ladders for staff interested in mental health/family support.
- Make use of Family Development credentialling programs, if available.

Be sensitive to the community and cultural meanings of mental health.

- Work with families and use community planning mechanisms to explore cultural issues related to mental health.
- Let families get to know the mental health consultants at a location where the families, children, and staff feel comfortable.
- Include explicit support of cultural traditions in efforts to promote wellness and cope with stress in families.
- Use explicit strategies and language to make mental health "user-friendly."

Tailor screening assessments and service strategies to levels of need.

- Use screening and assessment tools that have been tested and validated on Head Start children.
- Work with mental health consultants and teachers to target intensive services to those children in each classroom who show the most challenging behaviors.
- Adapt mental health strategies to the intensity of needs and strengths present in families served by the program.
- Use a "system-of-care" approach to meeting the needs of the most troubled children and families, including flexible support services such as one-on-one coaches and respite care.

Develop community connections to enhance strategic mental health initiatives.

- Take advantage of windows of opportunity to start or improve collaborations with mental health, family support, and substance abuse programs as well as community-based organizations working to address community problems.
- Forge partnerships with mental health training programs.
- Take advantage of Medicaid services and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Join in community planning efforts to create early childhood systems-of-care and/or comprehensive family support centers.
- Work with managed care providers to develop early intervention and outreach strategies for Head Start.
- Explore ways to help the most stressed Head Start families meet welfare-to-work requirements, building on effective mental health and family support strategies.

What Can Be Done at the State and National Level to Strengthen Mental Health Approaches in Head Start

Include mental health in the regional offices and the training and technical support system.

- Use the regional and national training and technical assistance system to help Head Start programs choose and use mental health consultants more

effectively, build staff mental health competencies, strengthen the intensity of family service work and use the newly promulgated Performance Standards as an opportunity to help programs plan for more responsive mental health strategies.

- Establish a staff position (or, at minimum, an advisory team) with expertise in mental health in every region to help programs and/or grantee agencies develop mental health strategies responsive to the needs of staff and families.
- Develop a system to track mental health approaches and strategies, as well as amount of service provided.
- Organize meetings of mental health consultants and coordinators in each region to share information about effective strategies.

Develop statewide collaborations for mental health in Head Start.

- Continue and expand the Head Start/State Collaboration Projects, and ensure that mental health issues are addressed by them.
- Develop Medicaid/Head Start and Part H/Head Start collaborations sensitive to the particular characteristics of these programs in each state.
- Encourage statewide meetings of Head Start mental health and family support/service staff with mental health consultants.

Provide strong national leadership.

- Gather routine information on mental health approaches used by Head Start programs.
- Create a nationwide model career ladder for Head Start staff interested in social services, family support, and mental health, and develop systematic internship strategies.
- Expand the pool of culturally-responsive mental health professionals in Head Start by developing well-structured volunteer initiatives in conjunction with mental health professional organizations.
- Provide ongoing support to programs to implement deliberate, holistic mental health strategies to meet the objectives of the proposed Performance Standards.
- Build links with ongoing national efforts, such as Start Healthy, Stay Healthy, mounted by the Center on Budget Policy and Priorities, to ensure that eligible children in child care settings, including Head Start, are enrolled in Medicaid and thus are able to access mental health as well as physical health services.
- Test strategies to apply research-based knowledge to strengthen the capacity within Head Start to prevent emotional and behavioral problems in children.

Support mental health-related research efforts.

- Incorporate measures on behavioral and emotional outcomes, as well as risk and protective factors, in all research carried out on Head Start populations.
- Explore how the Head Start experience, in general, affects emotional and behavioral patterns in children.
- Explore the effects of different combinations of mental health strategies in Head Start on all children, on children at risk of developing conduct disorder and other emotional and behavioral problems, on children with identified

emotional and behavioral disorders, and on families with different levels of stress.

- Conduct studies to determine the prevalence of serious emotional and behavioral disorders in young children served by Head Start, the prevalence of combinations of risk and protective factors that affect the development of such disorders, and variation in these disorders and factors across different kinds of communities.
- Examine the impact of managed mental health care on the delivery system for mental health in Head Start.

The message from the field is clear. The need to pay greater attention to mental health-related issues in Head Start is urgent; the strategies are emerging; and the opportunities to build a more coherent response over the coming years are too important to be ignored. *Lessons from the Field* suggests concrete, cost-responsive directions forged program by program through trial and error. Implementing these new directions more broadly will require public leadership by government at the federal, state, and community levels, as well as public-private partnerships. It will involve some new resources and redirection of existing resources. It will also require capitalizing on the positive aspects of devolution—greater flexibility at the state and community levels—and of managed care. But the task is achievable, the need compelling, and the vision becoming clearer.

CHAPTER 1

Setting the Context: Why Revisit the Role of Mental Health in Head Start?

The Historical Role of Mental Health in Head Start

The level of need in the Head Start community appears to have changed. Young children and their families, as well as staff, are facing ever-increasing levels of stress.

Philosophically, since Head Start began, it has maintained a commitment to mental health as an integral part of a child development orientation. In this context, mental health is defined broadly as promoting the healthy emotional development of children, supporting family strengths, identifying early signs of emotional and behavioral difficulties, and assisting families with special needs. Translating this vision into practice, however, has been problematic throughout Head Start's history.[7] This has been so for reasons which are as relevant today as they were in the 1970s.

- Mental health services, either for children or families, are defined narrowly as therapy. Yet there is great skepticism about how effective such therapy is for Head Start children and families.
- There is a reluctance to label troubled children as having emotional or behavioral problems.
- There has not been a well-developed system for giving the Head Start community technical assistance with implementing a broad range of mental health strategies.
- Research has not highlighted the impact that different approaches to infusing a mental health perspective in Head Start have had on outcomes for children, families, and staff, or on program quality as a whole.
- It has been difficult for Head Start program directors and others to find, or pay for, mental health consultants with expertise in dealing with young children and/or low-income families.

While these realities have been constant throughout Head Start's history, several other developments make this an important time to escalate the dialogue at the community, state, and national levels about the role of mental health in Head Start. This chapter highlights four sets of current factors that together compel attention to mental health issues in the context of Head Start.

The Level of Need in the Head Start Community

There is an emerging consensus (confirmed in some epidemiological data),[8] that American families in general, and Head Start families in particular, are facing greater and greater levels of stress, and that this stress has spillover effects on the Head Start staff and programs. For example:

- Staff report that children are showing more and more evidence of stress in the classroom, with a significant number exhibiting either withdrawn, aggressive or "out of control" behaviors that challenge the staff and sometimes threaten the overall classroom climate. In rare instances, Head Start programs, like many in the larger child care community, sometimes actually exclude children.
- A significant proportion of families with children in Head Start have intense and often complex needs. Community and family stresses such as substance abuse, domestic violence, HIV/AIDS, unemployment, depression, and community violence combine for many parents in ways that affect their ability to engage with their children and with Head Start programs. It is not uncommon, for example, to hear Head Start staff express frustration with their inability to engage families in the traditional parent involvement Head Start strategies (parent involvement also means aunt, grandparent or foster parent involvement).[9] It is also likely that these very same families will pose special challenges to Head Start and other programs seeking to help parents meet welfare-to-work requirements.
- Head Start staff too must cope with difficult stresses. For some, there is burnout related to the depth of need that they see. Others are coping with difficult realities in their own lives not unlike those facing the Head Start parents and children.
- As Head Start becomes increasingly multi-ethnic, staff face challenges in not only finding creative ways to strengthen respect for the different cultural backgrounds reflected in the children and families, but also in resolving work-related cross cultural conflict (such as the tensions reflected in different expectations about child rearing, particularly discipline).
- Children with serious emotional and behavioral problems appear to be under identified in Head Start. Program Information Reports from the 1994–1995 year suggest that only two-thirds of one percent of Head Start children are identified as having such disorders. But careful studies have estimated that a much larger percentage of the children could benefit from some form of planful intervention.[10] Further, anecdotal evidence suggests that often children with emotional and behavioral problems are instead identified as having speech and language problems. While this is seen as less stigmatizing, it also means the children, and their families, may not get the appropriate help.

New Developments in Children's Mental Health

During the past decade, the mental health community has focused largely on transforming the service delivery system for older children and adolescents with serious emotional and behavioral disorders, drawing on the principles of what has become known as a "system of care."[11] While this effort has only haphazardly served young children and families, the philosophy under-girding it, as well as the service and community strategies generated by it, clearly have implications for Head Start children who are showing signs of seriously troubled behaviors as well as those who seem to be at high risk of developing such problems. Although it is not known how managed care will affect the momentum of the children's mental health reform movement, to date, four key principles have supported the effort:

- A commitment to develop strength-based family-centered services, with parents involved as partners in the decision-making and treatment process for their own children, as well as participants in larger governance strategies. This parallels the framework that has grown from the family support movement, as well as the Head Start philosophy.
- A belief that children, even those with emotional and behavioral difficulties, should have as many opportunities as possible to participate in normal kinds of activities with children their age, with whatever supports are necessary.
- A commitment to use mental health dollars flexibly to respond to what families need, not just what mental health providers have traditionally offered (outpatient treatment, day treatment or placement in residential settings). Instead, mental health dollars have been used for home- and school-based services, including intensive in-home therapies, respite care, and coaches. This fiscal flexibility reflects a new clinical flexibility in responding to family needs.
- A recognition that mental health services alone, without the support of other agencies, rarely works. There has been a commitment to reach out to other community agencies involved with children, including the schools, child welfare, and in the case of young children, the early childhood community.

These four tenets are parallel to the core Head Start philosophy— a commitment to parent involvement, a belief in the power of integrating children with special needs in Head Start settings, a flexible approach to services, and a recognition of the importance of working with other community agencies and leaders. Yet while the philosophies are parallel, many in the Head Start community are unaware of these changes in service delivery and orientation within children's mental health—in part because they have been applied largely to the older and most seriously troubled children and adolescents.[12] Similarly, many in the mental health community are either unaware of the needs in Head Start or unfamiliar with issues facing young children and families. This appears to be changing. Community-based system-of-care initiatives focused on young children are slowly beginning to emerge, typically with a strong focus on prevention and early intervention.

New Opportunities in Head Start

There have also been important developments within the Head Start community. First, there has been a growing recognition of the importance of enhancing the quality of Head Start programs.[13] This includes a greater focus on the role of mental health within the context of Head Start, illustrated by the attention paid to mental health in the newly promulgated Head Start Performance Standards. Unlike previous standards, these emphasize the importance of having a mental health consultant on-site frequently enough to build a relationship with staff and families. Such standards provide the necessary (although not sufficient) context to encourage the development of more effective mental health strategies.

Second, there has been some emphasis on mental wellness in Head Start.[14] This approach has helped Head Start staff view mental health in the context of building child and family strengths. It is this approach that is reflected, for instance, in Early Head Start programs for infants and toddlers. For these programs, Head Start has asked that mental health be infused in child and family development activities, in staff development, and in community development, all of which are seen as integral to mounting effective programs for infants and toddlers.

Head Start Child Mental Health Performance Standards

(Excerpted from Federal Register, 45 CFR Part 1301 et al.; See Appendix C 1304.24 Child mental health)

1) Grantee and delegate agencies must work collaboratively with parents on issues related to parent education by:
   - Soliciting parental information, observations, and concerns;
   - Sharing staff observations of their child and discussing issues such as separation and attachment;
   - Discussing and identifying with parents appropriate responses to their child's behaviors;
   - Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;
   - Helping parents to better understand mental health issues;
   - Supporting parents' participation in any needed mental health interventions.
2) Grantee and delegate agencies must secure the service of mental health professionals on a schedule of sufficient frequency to enable the timely identification of and intervention in family and staff concerns about a child's mental health; and
3) Mental health program services must include a regular schedule of on-site mental health consultation involving the mental health professional, program staff, and parents on how to:
   - Design and implement program practices responsive to identified behavioral and mental health concerns;
   - Promote children's mental wellness with education to staff and parents;
   - Assist in providing special help for children with atypical behavior or development;
   - Utilize other community mental health resources, as needed.

Emerging Lessons from Research

A growing body of child- and family-related research about the long- and short-term consequences of early childhood programs also has implications for reconstructing a vision of mental health in the context of Head Start. Research tells us that intervening in the lives of at-risk children can help reduce later problems, such as school dropout or delinquency. The key to successful interventions seems to be intensity and quality of services, as well as the amount of attention paid to both family and child.[15] Long-term effects of early childhood programs on later outcomes, such as delinquency, have been found when intensive family support services were combined with high-quality early education.[16] All of the programs that had such effects featured low child-to-staff ratios, high levels of ongoing staff support and training, and parent support aimed at child development, parenting, and job and school goals. Most often these services were offered via home visits (the programs included the well-known Perry Preschool as well as programs in New Haven, Syracuse, and Houston). By offering intensive services to both parents and children, these programs seem to have affected a range of family and child risk factors for delinquency, as well as reducing antisocial behaviors and delinquency itself. Strengthening mental health supports to children, families, and staff is one way of enhancing the intensity of interventions and hence the preventive potential of Head Start.

For these reasons, then—the urgency of the need, the emergence of a new children's mental health orientation consistent with the Head Start philosophy, new interest from the mental health community in prevention and early intervention, and recognition from within Head Start about the need to focus on mental health—*Lessons from the Field* offers insights upon which to build new directions and initiatives, both for the Head Start community and for the larger early childhood community.

CHAPTER 2

Building Mental Health-Related Skills in Staff: Focusing on the Children

... building staff capacity to observe behaviors, model and promote healthy relationships within the program and help families build on their strengths and cultural traditions as they relate to their children offers a powerful way to improve mental health.

The long-term goal of improving mental health services in Head Start has always been to enhance outcomes for children and families. Traditionally, this has been accomplished through direct services to children and through work with parents. The findings of the Task Force on Head Start and Mental Health, reinforced in this study, suggest that building staff capacity to observe behaviors, model and promote healthy relationships within the program and help families build on their strengths and cultural traditions as they relate to their children offers a powerful way to improve mental health. For children who already see themselves (and seem to others) as out of step or not as competent as their peers, and for parents who see themselves as having little to contribute to their children's lives, (in one Head Start program we visited, the family service workers reported that families felt too beaten down to even visit their child's classroom, let alone volunteer), helping children and families relate differently and see themselves differently can be key to change.

The experience in the field suggest that building mental health-related skills of staff as they deal with difficult day-to-day issues in the classroom, make home visits or work with troubled families, can improve Head Start's direct services to children and families, enhance Head Start's parent involvement and family support functions, and build staff confidence in coping with multiply-stressed families. Building staff skills can also increase their own well-being, which in turn benefits the families they are trying to assist.

Enhancing mental health-related staff skills as a core mental health strategy is also challenging. It requires that the consultant be a trusted part of the program. It necessitates a funding stream that is not necessarily tied to the face-to-face services for individual children. And it can be tricky. Supporting staff in their work within Head Start is not the same as helping staff address their own needs, for example through an employee assistance program. But, as the following programs demonstrate, a mental health strategy focused on staff support can be an effective force for significant, program-wide change.

This chapter emphasizes, although not exclusively, strategies to help staff address mental health-related issues in children. (The next chapter highlights strategies that focus largely, although not exclusively, on helping staff help families.) In Nassau County, New York, skilled on-site mentoring has integrated mental health with other components of Head Start, particularly in classrooms. In Washington, D.C., sensitive, clinically-informed support of home visitors

raised not only the level of staff skills but also their self-confidence. In Eugene, Oregon, a training curriculum addressing children's attention deficits and hyperactivity went far beyond a one-shot workshop by providing ongoing support for teachers. In Chicago, a violence prevention program addressed staff feelings and concern about violence as an integral part of helping them help children to be non-violent. In New Haven, college students work with individual children.

On-Site In-Classroom Mentoring

Economic Opportunity Commission of Nassau County Head Start and North Shore Child and Family Guidance Center, New York

In many Head Start centers, collaboration with local mental health agencies or individual providers occurs on an "on-call" basis. A recent Head Start Program Information Report, for example, revealed that of the programs with access to a mental health professional, 46 percent indicated that the consultant was available only "on-call", without regularly scheduled visits.[17] Not surprisingly, this results in wide dissatisfaction. One of the clearest messages from the Head Start community who helped us carry out this study, as well as from the *Report of the Task Force on Head Start and Mental Health*, is that simply having mental health consultants available on an "on-call" basis does not work. The promotion of mental health is ignored, or is not integrated with the other program components. Staff do not turn to the consultant for help. Parents are suspicious. There is limited follow-through on referrals to outside mental health agencies, and when referrals do occur, Head Start staff may disengage themselves, not seeing themselves as part of an ongoing partnership to help a particular child and family.

Simply having mental health consultants available on an "on-call" basis does not work.

On Long Island, the North Shore Child and Family Guidance Center (NSCFGC) and the Economic Opportunity Commission of Nassau County Head Start program have developed a collaboration that moves well beyond the "on-call" model. Using a deliberate on-site strategy, the NSCFGC and Head Start created a mentor program to support staff in their work with "difficult" children.

The mentoring program evolved through a trial and error process. Dissatisfied with the traditional evaluation services they were providing to Head Start families, the staff of NSCFGC began to lead occasional "drop-in" workshops on mental health-related issues at the Head Start center. Although these workshops were well received by Head Start families and staff, there was still little sense of connection between the agency and Head Start.

In response to these concerns, as well as to the need in Nassau County for training and consultation for early childhood programs, the Child and Family Guidance Center established the Early Childhood Training Institute, which was privately funded by several long-term supporters of the agency. The Institute provides training workshops, parent programs, a "warm-line" for parents, and consultation to numerous early childhood programs in the county. In addition, staff training efforts, such as a five-week intensive course in working with children with difficult behaviors, were offered to Head Start

teachers and family service workers. This course has continued and has been so successful that many mental health professionals from the community have enrolled in it.

Training has not been limited to formal courses. At Nassau County Head Start, staff of the Institute offered on-site sessions focused on issues of greatest concern to Head Start staff, such as how to manage a difficult child. These sessions were so well received that they were expanded into a "mentor program." The program provides for an emotionally generous and clinically skilled staff member from the Child and Family Guidance Center to spend two half-days a week in the Head Start center, rotating from classroom to classroom, observing, modeling, being available, and providing another pair of helping hands and eyes. This mentor participates in monthly general staff meetings, as well as in more frequent "cluster" meetings with smaller groups of staff. The position is funded by cost sharing between Nassau County Child and Family Guidance Center and Nassau County Head Start.

In addition to working in the classroom, the mentor leads parenting groups, which meet regularly to discuss parental stresses, parenting issues, their children's behaviors, and other topics on their minds. In one group, made up of Spanish-speaking parents, the mentor co-leads with a bilingual parent, who translates an outline of each week's topics and acts as a translator during the sessions. Cultural issues have been productively addressed in this ongoing workshop. For example, the group was concerned with how one child's behaviors were being interpreted. The child would not look his teacher in the eye. This was appropriate in his South American culture, but was perceived as withdrawn and noncommunicative by the teacher. The mentor helped parents to discuss the meaning and importance of cultural practices that may be unfamiliar to staff. The mentor also helps foster discussions about culture in staff meetings—making it acceptable for staff to talk about cultural similarities and differences and how they are visible in the program.

The mentor works extensively to enhance staff skills with regard to mental health issues. One staff person noted that a conversation she had had with the mentor, which helped her to focus her feelings about working with the families, had been of "monumental" significance. The mentor had enabled

What On-Site Mental Health Consultants Do

On-site mental health consultants can:

- Help staff to understand and problem-solve when faced with challenging child behaviors, both in and out of the classroom;
- Provide a forum to explore cultural differences and workplace conflicts;
- Overcome resistance to mental health services by being a regular, reassuring presence at the center;
- Provide specialized workshops and training to Head Start staff on mental health-related issues;
- Offer a mental health and wellness perspective to cross-component case discussion meetings;
- Support staff in discussing their own stress and concerns, and how these factors affect their work; and
- Provide immediate and follow-up crisis intervention when crises occur.

Through this close and regular on-site collaboration, a shared sense has emerged that the critical mental health challenge is not so much diagnosing problems or building specific skills, such as setting limits, but is in supporting the staff in caring for children, and helping them ensure that children's emotional and social needs are being met in the classroom.

her to stop and think about the meaning of her work and to reconsider her approach to the children and families. Other teachers have written the mentor letters outlining how much they felt they had grown professionally as a result of her efforts with them. In addition, the mentor has helped staff to identify strengths in the parents, consider behavior problems in the context of what is happening in the child's world, and appreciate the stressors parents face every day.

One major aim of the collaboration is to help staff understand the context in which behavior occurs, including the family context. For example, the consultant helped the staff moderate their anger towards a child in a chaotic home situation (probably sleeping in a different bed every night), and whose behavior as a result was quite disruptive. In other instances, North Shore Child and Family Guidance Center staff have helped address conflict in the workplace, by encouraging staff to separate their personal reactions from professional responses.

Through this close and regular on-site partnership, a shared sense has emerged that the critical mental health challenge is not so much diagnosing problems or building specific skills such as setting limits, but is supporting the staff in caring for children and helping them ensure that children's emotional and social needs are being met in the classroom. To this end, NSCFGC is committed to mentors who are particularly empathic and respectful toward the Head Start community; in recent work involving substance abuse, the center relied on a staff member who was once a Head Start parent and who is now an expert in substance abuse.

In response to the collaboration, Head Start teachers report a more relaxed work environment and increased ability to solve problems with challenging children. The director reports feeling supported instead of isolated when faced with crises. Staff workshops have enriched workers' knowledge of such topics as understanding temperament, how three-year-olds and four-year-olds differ developmentally, and how to discipline children with extreme acting-out behaviors. The mentor's work with the staff, children, parents, and administration has initiated a "snowball" effect, increasing awareness of and sensitivity to the mental health of the Head Start families at all levels of the program.

The partnership has not been without its challenges. The mentor's initial year-long work with one of the grantee's centers had been extraordinarily successful. Yet, in a sadly typical scenario, the next year, that center's budget no longer permitted her to work there, so she shifted to another center. However, she left a powerful legacy, having trained the director at the first center to continue her work. This, in fact, led to a re-thinking of the approach. The current goal of the partnership is for the mentor to rotate yearly among the centers in Nassau County and train one Head Start staff person at each center to carry on the mentoring work.

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Supporting Home Visitors through Weekly Consultation

Rosemount Head Start, Washington, D.C.

Home visiting is a family support strategy with roots in the work of the urban settlement houses of the late nineteenth century. Home visiting services have enjoyed a burst of popularity in the past decade, based on the results of careful evaluations demonstrating their benefits for parenting practices, early child development, and improved adult life-course outcomes, such as parent educational level and subsequent childbearing. Recent reviews of the research on home visiting find that this strategy is particularly powerful as part of more comprehensive programs, which provide additional components such as high-quality educational child care and support for parents' career and school goals.[18] Some of these comprehensive programs have shown impressive long-term effects on children's future school adjustment and delinquency.[19] Home visiting components may be particularly crucial in achieving preventive mental health outcomes; one expert has likened the change-promoting potential of a home visitor family relationship to that of the therapist-client relationship.[20] Although all Head Start programs are required to carry out a minimum of two home visits a year, few, except those serving infants and toddlers, are primarily home-based programs. In many, however, family service workers, sometimes with teachers, report making more and more home visits.

This, coupled with the rapid growth of the Early Head Start initiative, focused on infants and toddlers,[21] means it is crucial to address a relatively neglected aspect of home visiting: training and ongoing support of the visitors.[22] Because home visitors must work on their own without the immediate peer and supervisory support available at center-based programs, training and support are especially important. The Rosemount Head Start program, in Washington, D.C., has addressed this challenge head-on. The program's efforts demonstrate the complexity of the training issue and the importance of mental health-sensitive support.

The Rosemount Head Start program provides both center-based child care and home visits to the families it serves. The home visitors receive a manual when they are hired, but because they do not start as a cohort, there is no formal orientation or training program. Rather, each visitor maintains a mentoring relationship with a more experienced visitor, and accompanies the mentor to families' homes for a short period. The program also provides periodic training sessions to the visitors, largely to impart information.

For the past several years, Rosemount home visitors have had a once-a-week support and consultation session with a trained family therapist

One home visitor reported that both her confidence in her ability to work with Head Start families and her general self-esteem have grown substantially through her participation in the group meetings with her peers and the consultant.

generous enough to volunteer her time in conjunction with the American Association for Marriage and Family Therapy (AAMFT). One particular consultation/support session we observed between the 14 home visitors and the family therapist consultant highlighted the enormous complexity of mounting a successful home visiting program. The home visitors expressed concerns about the overwhelming stresses in the lives of the families that they visited, their need to understand their own reactions, and their desire to more effectively transmit the skills that make up the formal home-based curriculum. During the session, home visitors discussed the issues and then role-played a home visit, alternately taking the role of the parent, the home visitor, and the children. The therapist carefully guided the staff through the difficulties of responding to the needs of the parents and the children, who clamored for attention from both parent and the home visitor. She helped them explore the complex emotions embedded in their relationships with the families they serve, and suggested ways the home visitors could use those feelings effectively in their work. At Rosemount, the home visitors came from many different cultural and linguistic groups, including Latin American and Southeast Asian countries. This increased both the challenges the workers faced and the richness of their experiences. The warm and accepting environment created by the consultant at Rosemount permitted honest discussion of different cultural traditions and expectations. Her open approach to these and other topics was clear when the staff talked with the therapist and with each other. The therapist's effectiveness was underscored when the staff told us, only partly in jest, that they would trade all of the formal training sessions for more time with her.

The impact of the weekly consultation on the home visitors has been significant. One home visitor reported that both her confidence in her ability to work with Head Start families and her general self-esteem have grown substantially through her participation in the group meetings with her peers and the consultant. She cited an example of how her skills have grown with a story of one family where the father did not want the mother to work. The home visitor suggested that all three meet to discuss the problem (a meeting she learned how to facilitate through her work with the volunteer consultant). The home visitor started the meeting by asking the father: "So you have small children—what else bothers you about her going to work?" When the mother interrupted the father's reply, the home visitor mediated the interaction by saying, "We'll hear from him first, then from you." She gently led the couple through a discussion of the pros and cons of the wife's working, and then asked whether the wife could take a part-time job for a trial period. The couple agreed. The home visitor felt that she showed them how to work out conflicts, leading them through the process so that they would feel more comfortable doing it on their own. She also helped them set consistent limits with their child, who was behaving aggressively. By emphasizing the importance of agreeing in child rearing, and following through on discipline decisions, she helped the couple work together in raising their child. The child gradually showed improvements in her behavior. The home visitor said that she felt she didn't have the skills to do this kind of work; "but [the consultant] showed us that we have the personal resources and taught us skills to help families express and resolve conflicts about their childrearing."

The consultant has helped the home visitors develop a range of skills, including setting limits with overly demanding families, using their anger constructively when family members provoke them, and staying connected to parents while resolving conflicts between them. In addition, through the help of the consultant, the home visitors learned that helping parents to accomplish a task was more empowering than doing it for them. For example, instead of accompanying parents to the social services office repeatedly, visitors learned to go with parents the first time and then help them advocate for themselves the next time.

The experience of the Rosemount home visitors shows the many benefits of consultation by a skilled, nurturing mental health professional. The visitors were trained in a wide range of skills in working with families experiencing multiple stressors. Perhaps more importantly, their own self-esteem and self-confidence were enhanced by the consultation sessions. They did not feel as burned out after each week of home visits, and they felt truly supported in their often isolating work.

The success of this volunteer consultant effort in part spurred the development of a demonstration initiative by the AAMFT that matched family therapists with Head Start programs and provided supervision for them from senior AAMFT therapists. As further incentive, the experience helped the family therapists obtain accreditation.[23]

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Addressing Behavior Problems Through Ongoing Training and Technical Assistance

The Management and Prevention Program (MAP), Eugene, Oregon

Head Start staff from all over the country report concern about increasingly disruptive behavior among children, marked by constant running around the classrooms and halls, frequent yelling and hitting, and continual disrupting of other children's activities. These behaviors in early childhood, when serious, can place a child at risk for future academic problems, for problems in social interaction, and for conduct disorder, especially when accompanied by early aggressive behavior.[24]

Staff also report a great need for specialized training to help them cope with children who show such behaviors. There are a number of manuals available. The National Training Contractors in Health, for example, has developed one manual on mental health for Head Start, entitled "Caring Relationships—Resilient Communities: Promoting Mental Health," which addresses some of these challenges; it is currently available from the Head Start Bureau in Washington. There are also various informal manuals used in

Once a module is completed, a project coach visits the sites, helping teachers integrate their newly developed skills into daily classroom activities by providing on-the-spot feedback and assistance.

programs (a few of them are listed in Appendix A). However, systematic, hands-on training initiatives are few.

One model of training and technical assistance that has been recently developed to target difficult behaviors, particularly those characteristic of attention deficit disorder and hyperactivity, is the Management and Prevention Project (MAP), developed by school psychologists at the University of Oregon.[25] This training system is currently in its second year of implementation at Lane County Head Start in Oregon as well as at a local early childhood consultation center, Community Options. MAP combines a didactic component with a structure for ongoing technical assistance to a program, which continues after the initial training workshops have ended.

The didactic part of the program involves a comprehensive series of modules that focus on topics such as team collaboration, education about attention deficits and related behavior problems; the effects of environmental arrangements such as scheduling, monitoring, and classroom management on behaviors; the promotion of social competence and preacademic skills; and the importance of family education and support. This training is targeted to Head Start and other early childhood staff, as well as to early childhood specialists in the field of mental health, and is spread out over several months. The curriculum is notable in its comprehensiveness, and its recognition that behaviors are embedded in a context that includes the classroom and the family. Team collaboration among Head Start family service, education, and social services staff, and mental health consultants is emphasized in addressing the problem. Staff receive training on such specific topics as how to make the classroom environment less distracting, how to provide clearly defined areas for children with attention problems, and how to modify scheduling to reduce the frequency of transitions between activities. Teachers have learned how to identify behaviors that may be early signs of hyperactivity or attentional deficits. They are then trained to teach adaptive social interactions and encourage concentration on single activities so that the behaviors do not worsen into those associated with attention deficit/hyperactivity disorder and/or conduct disorders.

The series of workshop modules is only one part of the MAP project. Once a module is completed, a project coach visits the sites, helping teachers integrate their newly developed skills into daily classroom activities by providing on-the-spot feedback and assistance, and helping staff further develop their skills in working with children with behavior problems. Additionally, in an echo of the mentoring approach used in Nassau County, project staff train certain staff members to become coaches, so that they can continue the work of technical assistance in-house in subsequent years. The "apprentice" coaches accompany project staff on their coaching activities, observing, working alongside, and finally establishing themselves as coaches in the program.

Staff response to the MAP project at Lane County Head Start has helped to inform the MAP staff about aspects of the training that may need to be modified. Not surprisingly, the degree of team collaboration for MAP has varied across the different sites in Lane County. However, the Head Start staff are generally enthusiastic—they appreciate that this program is more than a series

of workshops. One staff member noted, "It's not a one-shot deal, where you're left cold to interpret all the workshop materials." Teachers have noticed effects, even early in the training: a teacher reported, for example, that the level of distraction of children has gone down in her classroom after efforts were made to lower the level of stimulation. One impulsive child had a very hard time staying with one activity for more than a minute. The coach in his classroom suggested using a timer for a brief period so that he could be encouraged to stay in an area for two or three minutes. This child learned quite quickly to increase his level of concentration. As coaches come on-site, they represent a sustained presence in the program. They are viewed as strong additions to the classroom, providing much-needed hands-on suggestions and ideas for addressing challenging behaviors.

The project staff at MAP also consider the program suitable for training of mental health consultants and coordinators, and plan on developing written materials and disseminating them nationwide as the project is replicated. A current process evaluation of the curriculum focuses on gathering feedback from teachers and other staff to inform further development of the training modules. Outcome evaluation is also planned, with pre- and post-test assessments of teacher activities and child behavior and adjustment.

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Helping Families and Staff Prevent Conduct Disorders: The Partners Parent Training Curriculum

Several years ago, Dr. Carolyn Webster-Stratton and her colleagues developed the Partners Parent Training program to help families with young children with identified conduct disorders who were referred to a mental health clinic. The aim of the Partners curriculum is to promote parental competence, child social competence and home school connections in order to enhance protective factors and reduce the risk of early onset of oppositional defiant behavior and other forms of anti-social behavior. Dr. Webster-Stratton has tested out an adapted version in Head Start with over 500 families.

The Partners Parent Training, is characterized by:

- Parent meetings over eight or nine weeks.
- Use of video taped culturally diverse vignettes as the basis for active group discussion and exercises. (The vignettes address such topics as helping children play, helping children learn, using praise and encouragement, setting effective limits, handling misbehavior, teaching problem-solving, and giving and getting support.)
- Training Head Start family service staff (and sometimes parents who have been through the program) as co-leaders of parent groups.
- Providing a shortened (16 hour) training for the teachers to increase consistency between home and Head Start.
- Rigorous evaluation strategies comparing the impact on Head Start parents who had been through the program compared to those who had not.

Parents reported that 30 to 36 percent of the children were in the clinical range for aggressive and non compliant behaviors. Teacher reports and independent observations suggested 16 percent were exhibiting such behaviors. Moreover, as a group the mothers, as is true of many Head Start parents, also had difficult experiences: 21 percent had their first child as a teenager; 16 percent had at some point lived in a shelter; 28 percent had a history of substance abuse and 45 percent had been physically or sexually abused as a child; and 20 percent had some involvement as a parent with child protective services. Consistent with other data on Head Start parents (see Chapter 3), 42 percent of the sample were experiencing moderate or severe depression.

The evaluation found that one year later, the children of the participating mothers showed significantly fewer negative behaviors and conduct problems, less noncompliance, less negative affect, more positive affect and more positive social behaviors than children whose mothers did not participate. Parents were also more likely to be involved with kindergarten activities and to interact with teachers. The only group of parents who did not seem to benefit were those who had a history of psychiatric illness. Parents attended the Partners sessions at a rate 10 times greater than the normal parent education evening events provided by the Head Start centers not receiving the intervention. The teachers reported a high level of satisfaction with the program because of increased parent involvement in the classroom. Family Service workers reported the program was like the "hub of a wheel" fostering trust and a supportive network among all the families. They redefined this role to focus on providing effective comprehensive parent programs rather than acting in the case worker role of primarily making referrals to support services. Currently the Parent Program is being replicated with the addition of a comprehensive teacher training program, including classroom management, transition planning, social skills and problem-solving training.

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For more information about the Partners curriculum see:

C. Webster-Stratton & M. Herbert. (1994). Troubled families-problem children: Working with parents: A collaborative process. New York, NY: Wiley & Sons.

What to Look For in a Mental Health Consultant

In the course of this project, we talked with many Head Start staff involved in a variety of different partnerships with mental health consultants. Over and over, we would hear the same words and phrases from staff when they described mental health consultants who were truly integrated into the life of their Head Start program. These are some of the characteristics of successful Head Start mental health consultants.[26]

- *They are on-site on a regular and sustained basis.* Effective mental health consultants are at the Head Start program often enough to become familiar both to staff and to parents and children. They are willing to work not only with individual children, but also with parents (through parent workshops, support groups, etc.) and staff (both in the classroom and by attending and contributing to regular staff meetings).
- *They are involved in multiple components of the program.* The mental health consultants who seemed to have the greatest positive effects on a program were, not surprisingly, involved in multiple areas, such as education *and* social services. These are consultants who provide in-classroom tips, suggestions, coaching and mentoring to teachers working with difficult-to-manage children; consultants who co-lead, with family service staff, support groups for parents; consultants who attend weekly cross-component meetings to discuss individual families.
- *They have knowledge, and the ability to impart it, in areas most relevant to the Head Start program.* Mental health consultants should have some experience with the range of mental health-related issues within Head Start programs and knowledge of how to address them in ways consistent with the Head Start philosophy. Mental health-related areas might include identifying and reducing behavior problems, responding to incidents of community violence, helping families struggling with substance abuse, and enriching parenting workshops with attention to stress, coping, and mental health. Consultants should be able to impart their knowledge to staff in different components (social services, parent involvement, education, and health) through both informal consultation and more formal workshops and training sessions.
- *They are able to learn from staff.* Consultants should not only impart their knowledge and skills to staff, but also be able to learn from the staff and build on their knowledge of Head Start families. Successful relationships between Head Start staff and consultants emphasize mutual learning and respect, as well as a shared commitment to respecting the strengths of families while acknowledging real problems.
- *They understand the Head Start philosophy.* Effective mental health consultants understand the family-focused nature of the Head Start model and view individual children in the contexts of their extended family and support networks, which include Head Start staff from all components of the program.
- *They are able to work with cultural differences and similarities.* Effective consultants are not only comfortable working with ethnically diverse families, respecting their cultural differences and similarities, but are able to discuss cultural issues and tensions openly with families and staff when they arise.
- *They have collaborative skills.* Effective mental health consultants are able to work as team members with teachers, family advocates, coordinators, and directors at Head Start centers, respecting the different roles and skills of each.

The Rainbow House Choosing Non-Violence Curriculum, Chicago, Illinois

What happens around here that's violent?

"On the fire lane, they shot a boy in the back of the head. The BD [a gang] had the gun, but the boy didn't see the gun was loaded."

"They are smoking blunts [marijuana in cigar paper] that are in brown paper. They use cigars and smoke them. They put bud [marijuana] in the cigars. Bud is brown. The police chase the bad boys that have bud and they be shooting them bad boys."

How do you feel when you see violence?

"I feel like crying and you get so mad!"

"I be having bad dreams about somebody trying to stab me with a knife."

— From a discussion with children attending the Robert Taylor Homes Head Start program, Chicago, after a weekend of violence in the housing project.[27]

The extent to which violence is a constant threat to the lives of many families with young children varies community by community, but sadly, it is an ever present reality in many Head Start communities. As one Head Start staff member told us, "The kids know. They tell us who's in jail, who got shot last week, whose brother is in which gang." Sometimes, the violence directly affects the program. In Chicago, for example, some Head Start programs plan to install bulletproof windows and security systems to prevent a repeat of a gang walking in and threatening the children and staff. In other Head Start programs, outside play is shortened or eliminated, because of fear of shootings. Head Start staff also know that this exposure to violence takes its toll on children. There are reports of funeral play in the doll corner from all parts of the country.

Increasingly, clinicians and others are beginning to document the impact on young children of exposure not just to family violence, but to community violence. The effects can range from withdrawal to the symptoms characteristic of post-traumatic stress disorder to aggressive behaviors.[28] Since early aggressive behavior is the single most powerful predictor of later antisocial behavior in adolescence,[29] and exposure to family conflict and violence is also a strong risk factor for later problematic behavior, this has enormous implications for mental health in the context of Head Start.[30]

In Chicago, a city racked by violence in many of its neighborhoods, a battered women's shelter named Rainbow House has for the last eight years tried to stem the tide of violence through prevention strategies. Noting that the roots of violence stretch back to the childhoods of many perpetrators of family violence, Anne Parry, a staff member at Rainbow House, began domestic abuse prevention workshops at the high school level. After learning that high school students were already well on their way to being abusers, she went to elementary schools in Chicago and developed a curriculum for primary grade children to more broadly prevent aggressive behavior. The focus of the curriculum was to get children to talk about their anger and aggression and to build social skills through direct training and long-term cooperative projects

The philosophy is that staff should be helped to cope with their own stress and anger before training children to be nonviolent. Protocols for staff training were developed collaboratively, through a task force of early childhood educators from Head Start programs across Chicago.

with other students. Children were given the skills and options to react to interpersonal conflicts in non-aggressive ways. With some modifications, Anne Parry also began to use the curriculum at preschools in the city, in a collaboration with the Department of Human Services of Chicago, which is a large grantee responsible for 13,000 Head Start children.[11]

Staff training for what is known as the Choosing Non-Violence Curriculum is extensive and intensive. It involves engaging staff in discussing their own feelings and attitudes toward anger and violence. The philosophy is that staff should be helped to cope with their own stress and anger before training children to be nonviolent. Protocols for staff training were developed collaboratively, through a task force of early childhood educators from Head Start programs across Chicago. Through task force meetings, the concerns of teachers were identified and then incorporated into the curriculum. Concerns included issues of gender and violence, the impact of stress on the tendency to be aggressive, and discipline without violence.

As the program has developed, training has begun to move away from one-shot workshops to longer term "booster" sessions, which help teachers integrate the Choosing Non-Violence curriculum into their everyday work. The success of the project has been tangible to many Head Start staff. One skeptical teacher implemented the curriculum reluctantly, noticing only a few improvements in the first few months. He continued to implement the curriculum, and was then able to observe a significant reduction in aggressive behavior among the children. An education coordinator at a multisite center similarly has noted a gradual reduction in fighting among the children in the classrooms she sees. Teachers told us that children, instead of fighting, learn to talk about what is bothering them, to say, for instance, "Stop doing that to me!" instead of simply hitting another child. Teachers also agreed that the initial emphasis on opening up their own feelings about anger and violence was painful but valuable preparation for the child-focused portion of the curriculum.

Parents too are increasingly involved in the workshops. Posters proclaiming "Violence-Free Zone" have proven effective not only in the classroom, in deterring children from fighting with one another, but in homes, where parents have noticed that their children who have been through the curriculum "train" their siblings by pointing out the poster. One parent mentioned that her daughter uses the poster at home by dragging siblings who are fighting to the poster to get them to stop.

An evaluation of the Choosing Non-Violence curriculum is currently being carried out by Professor Nancy Matthews of Northeastern Illinois University. So far, the evaluation has focused on process issues such as staff responses to the training, particularly on areas of strength and weakness that they see in the curriculum. Plans for future evaluation include investigation of the curriculum's effects on children.

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Coping with Crises: Gunfire

The Choosing Non-Violence Project has developed a series of crisis response protocols to help early childhood programs deal with potentially frightening and dangerous situations that occur when children are participating in activities both inside and outside the center. These situations include gunfire near the center, gang fights near the center, violence outside the center when children are also outside, violent adults in the center, violent adults with weapons in the center, and personal and domestic violence affecting staff, parents, or children. The excerpt below, dealing with gunfire near the center, is reprinted with permission.

Gunfire near Center/Classroom; Children in Center/Classroom

1. Be alert.
2. Act quickly.
3. Speak in a calm tone of voice.
4. Move everyone away from windows/doors into corridors or to a higher level. Do not look out!
5. Lock Center/Classroom doors.
6. Get down on floor.
7. Notify other staff/director.
8. Call police; identify as "(NAME), director of _____ Center."
9. Reassure children honestly—"We're doing everything we can to make sure you're safe." "We're here and we are going to take care of you the very best way we can." "I know this is scary, but we are here together. You can help by staying down, listening carefully and cooperating."
10. Note time when police arrive.
11. Document the incident afterwards. (Use Incident Report Form.)
12. Determine appropriate way to notify parents—verbally, note home.
13. Talk with the children. Listen to the children. Affirm their feelings. Share your own feelings. Ask them how they felt and how they feel now. Let them vent! Let them talk!
14. Do follow-up activities (art, music, drama, etc.) to help the children process the experience. Allow time during free play for the children to process the experience. Free play is a wonderful vehicle for children to spontaneously respond to the feelings they have. Free play time may also alert teaching staff that other follow-up activities may be needed.
15. If police response was positive, the director should call or write to the precinct watch commander commending the department for good service.
16. If police response was poor, the director, a teacher, and a parent representative should visit the watch commander and communicate their concerns. Bring documentation—date, time, location, description, incident report form, number of children involved, number of calls to police, response time, etc.
17. Determine if outside counseling, processing would be beneficial for staff, parents, and children.
18. Provide staff with an opportunity to talk about the incident, evaluate performance, make recommendations for the future, recognize accomplishments, etc. If staff are uncomfortable with children talking about the incident at the lunch table or informally during play, this may be an indicator that staff need help processing the experience.

Caring for Children in Dangerous Times is available for purchase from the Rainbow House Institute for Choosing Non-Violence, P.O. Box 29019, Chicago, IL 60629, phone (312) 521-5501.

Using College Volunteers: Jumpstart, New Haven Connecticut

Head Start teachers frequently report that one of their greatest challenges is how to provide the intensive services which aggressive or withdrawn children need, when their own attention is spread across so many other children and families. The Jumpstart program, begun in 1993, provides just such an opportunity to children whom Head Start teachers feel need that extra help, using college volunteers.

Jumpstart was begun by two Yale University undergraduates, Rebecca Weintraub and Aaron Lieberman, who had worked during their summers at a camp for children with emotional and behavioral problems. Many of the children showed remarkable improvements over the course of the summers and developed close and trusting relationships with their counselors; many of the children were also in Head Start during the year. The two undergraduates wondered at the end of each summer whether the changes would last. Out of this concern grew the idea of integrating the model of intensive one-on-one and group activities with Head Start. With the help of Professor Edward Zigler of Yale, one of the co-founders of Head Start, a pilot project was begun in 1993 to place the Jumpstart model in several Head Start centers in New Haven.

In sites with the program, near the beginning of the Head Start year, teachers choose a few children from their classroom who are showing challenging behaviors, and who they feel might benefit from the extra attention which Jumpstart provides. Then the parents of those children are informed about the program, and invited to participate. Each participating child is then paired with an undergraduate counselor (no counselor is responsible for more than one child).

The counselors are from local universities. Each receives training and on-going supervision and support in how to plan and carry out activities with their child, and also with other Jumpstart children. They participate in an initial 3-day weekend training session, and also attend weekly supervision sessions with team leaders, who are former Jumpstart counselors with extensive experience. The education coordinator for Jumpstart provides materials for topics to be explored in the ongoing training. She is also available for consultation, through e-mail, to all of the Jumpstart counselors.

The Jumpstart children stay twice a week for two to three hours after the normal Head Start day is over, in unused Head Start classrooms, engaging in individual and group activities. Emphasis is placed on prosocial behaviors and reading (early verbal ability has been associated with higher school success and lower levels of behavior problems in later childhood in many studies[12]). Parents are involved through home visits, and through periodic parent meetings and activities. The counselors also meet regularly with teachers, to both inform and be informed about which behaviors most concern them, and how to best work with those behaviors. The counselors are paid through the Federal work-study program, and thus come at no cost to Head Start.

By targeting help to the few most challenging children in a classroom, Jumpstart can create real changes not only at home, but also in the classroom climate. Teachers report that children who were once "ringleaders" in spurring

Jumpstart's overall goal has recently shifted towards preparing the Jumpstart counselors who are interested in becoming future Head Start teachers. In this way, the program not only enriches mental health and family support in Head Start, but prepares the next generation of Head Start staff.

Helping Withdrawn Children: Latisha's Story

One parent related to us how Jumpstart's extra support and collaboration among teacher, parent, and Jumpstart counselor brought about remarkable changes in her child. This parent, a foster mother of several children, had a four-year-old child named Latisha (not her real name). She would alternate between being shy and withdrawn, on the one hand, or throwing tantrums, on the other. At home, Latisha had difficulty doing things by herself, such as taking a bath or putting on her shoes. She would demand that her mother do these tasks for her. At school, she would shut out other children in her class.

Although initially skeptical, as Latisha's foster mother saw changes in Latisha, her enthusiasm grew. The counselor met with the mother at home to discuss how she planned to help, and to suggest some similar things that could be tried at home. The counselor also met with the teacher in ongoing discussions of Latisha's progress. Through these meetings, the actions of all three were coordinated. In the mother's words, "whatever the Jumpstart counselor knew the teacher knew, and I was doing what they were doing—we were all working together."

The changes in Latisha were quite dramatic. Where she had once been shy and uncommunicative, she is now able to express herself in words. She came home able to do more things by herself, less fearful of accidents or mishaps. She also now shares toys and books with her siblings, rather than always insisting that it is her turn.

other children's aggressive behavior became positive influences on their peers, rather than negative ones. Some teachers have also noticed a classroom-wide change in the incidence of aggressive, acting out behaviors after the Jumpstart program. Jumpstart's overall goal has recently shifted towards preparing the Jumpstart counselors who are interested in becoming future Head Start teachers. In this way, the program not only enriches mental health and family support in Head Start, but prepares the next generation of Head Start staff.

Jumpstart is not meant to replace the Head Start responsibility to address the needs of children with serious problems. (A Jumpstart counselor could, however, be a treatment extendor, be included in the treatment planning process for such a child, along with the Head Start teacher, and could help to carry out that treatment.) Nor is Jumpstart a substitute for a larger mental health strategy that supports staff, families, and communities. But Jumpstart can play an invaluable role. The program aims to reach precisely those children who do not exhibit behaviors of the intensity to warrant a diagnosis, but nevertheless could greatly benefit from individual attention. By catching these children before their behaviors become established, and by helping teachers, parents, and counselors to work together consistently in their caregiving, the Jumpstart program, working in tandem with Head Start staff, may help prevent emotional and behavioral problems later in childhood. Although no data are available as yet, Marion Glick and Edward Zigler of Yale University are carrying out an evaluation of the Jumpstart program.

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Addressing the Needs of Homeless Head Start Children and Families

St. Bernard's Head Start and the Center for Preventive Psychiatry, White Plains, New York

Homeless families in Head Start face extraordinary pressures, even by the standards of other families in poverty.[33] In White Plains, New York, a collaboration between the local mental health center and a Head Start program for homeless families combines this therapeutic model with extensive support for parents, in an effort to meet the extraordinary level of need in this population.

The St. Bernard's Head Start program became a part of Head Start in 1987, at the instigation of the local Department of Social Services. The program serves homeless families in the White Plains area, with approximately 75 children coming from four shelters. The director estimates that the program serves most homeless preschoolers in the county. Observations of the staff fit those of others working with multiply-stressed families. The staff feel the parents can be very needy, and have some difficulty meeting the emotional needs of their children. Staff are seeking and getting training in working with these often traumatized children, who have been repeatedly exposed to violence and substance use in homeless hotels and shelters.

The St. Bernard's mental health services began with the development of a collaboration with the Center for Preventive Psychiatry, a community mental health center. Initially, services were provided in a traditional model, with occasional on-site consulting and pullout therapy for children with emotional or behavioral problems. Neither the mental health consultants nor Head Start teachers were satisfied with this arrangement. Teachers did not like the fact that mental health consultants were not a sustained presence at the center; nor did they agree with the emphasis on identifying serious problems. They felt that although the consultants provided them with useful advice, they were not on the firing line in the classrooms. An early effort to provide group therapy to the most difficult children was viewed by the teachers as creating more problems. Boys came back from the groups "off the wall" and had difficulty reintegrating with their classroom. In addition, attempts to have parents come to the clinic were usually unsuccessful, even though it was located only a few blocks from the center.

Finally, in 1990, two mental health professionals from the center began a part-day therapeutic classroom for the most troubled children, with their time

partly supported by the Center for Preventive Psychiatry and partly by Head Start.[34] The goal of the classroom is to help children give voice to their feelings and experiences within a safe, structured environment. Because of the extreme instability of many of the children's lives, a reassuring, consistent schedule of activities is followed every day. The aim is to make it easier for the children to remain in the regular classroom for longer periods of time. Parents are encouraged to visit the classroom and share their own experiences with the children at any time. A talking circle ensures that each child has a chance to share what is on his or her mind. The day that we visited, Cal (not his real name) sat with his father holding him and talked about feeling bad because his mother was so sad, and his father had been so angry with him earlier. This child's mother had made many suicide attempts, and Cal's older brother, who had burned Cal, was in a residential placement. Cal and his father had just moved into a permanent apartment. The therapeutic classroom provides a setting where both children and parents from families with multiple stresses like Cal's can receive a degree of support that is difficult, if not impossible, in a standard classroom, and can also experience a new way of communicating with others. While the notion of pulling-out children and placing them in settings with only other troubled children is controversial, the presence of on-site therapists from the center, together with teachers from Head Start, ensures that each child receives ample attention and that the special classroom is not perceived as very different from other classrooms.

St. Bernard's has tailored its services to the needs of homeless children and families not only in the intensity of its services, but through several other innovative strategies, as well. One chronic problem among this population is the frequency of moves among families. Typically, a child receiving mental health services at one Head Start program would have to start all over again after a move to a different area. At St. Bernard's, children in the therapeutic nursery can retain their close attachments to their therapists and classroom, even if their parents move out of the St. Bernard's neighborhood. Such children qualify for medical transportation (within a reasonable distance), and continuity in their therapy can be maintained. In addition, the therapeutic classroom eases the transition to kindergarten by retaining, for a short time, children who have just turned five who have afternoon kindergarten classes. With the extra help in the morning, these children have adjusted well to kindergarten.

Like the Nassau County Head Start center, the St. Bernard's center experienced a "snowball effect." The success of the therapeutic classroom and the on-site presence of mental health staff resulted in a recognized need for a stronger mental health component in all the classrooms and in efforts to support the very effective work of two Head Start family service workers, particularly the one who works most closely with the parents. Family service workers have gone on to develop close collaborative relationships with the two mental health consultants, as well as with case managers in the shelters where the families live.

Teachers also felt more supported in coping with crises. For example, when the mother of one of the four-year-olds was stabbed, the mental health consultant helped staff as well as children share their sadness and talk about what had happened. The teacher's comfort level in talking about violence with

the children (something she had not been willing to do before) was enhanced, and she was able to provide considerable help to the class.

In addition to an emphasis on innovative on-site treatment approaches, the St. Bernard's center has a strong preventive family support emphasis. Reaching out to the community, a staff person from a local Family Resource Center visits once a week, giving parents a special time: breakfast at the center and play time with the siblings of their Head Start children. The therapists play a role in encouraging families to participate. Parents stay on for their own activities, while child care is provided for the siblings. Many of the parents support each other in developing their skills; one group began to establish a cooperative bakery.

One unique example of the St. Bernard's approach to parent support addressed parents' needs to inform themselves about health care changes. The New York State Medicaid program has recently begun to change over to a Medicaid managed care program. This program allowed Medicaid enrollees a period to choose from six managed care companies (after the deadline passed, they would be automatically enrolled in one of the six). Representatives from these companies had begun to show up at local social services offices and AFDC offices, offering brochures with scanty information. Parents from St. Bernard's had many questions about the relative advantages of these managed care plans. Head Start staff and staff from the Center for Preventive Psychiatry helped parents prepare questions for a meeting with representatives of all six companies (questions, for instance, about which doctors, hospitals, and pharmacies in the area they could use under each plan). This support helped the parents voice their concerns during the meeting. They have since become savvy about the differences among the six plans and have made informed decisions about which to choose.

The partnership between St. Bernard's Head Start and the Center for Preventive Psychiatry has developed successfully in part because staff from both agencies are willing to work through conflicts. For example, there has been disagreement among therapists and Head Start staff about differing beliefs concerning parenting practices. Over time, both sides have made accommodations to the other's point of view, and there has been ongoing

Helping Staff Cope with Emergencies

All too often, Head Start programs face unexpected crises that threaten the well-being of staff, families, and children.

- The death of a staff member or family member.
- Community violence in the center, outside the center, or affecting a staff or family member.
- Domestic or personal violence affecting a staff or family member. (For example, an irate parent enters the Head Start program, frightening the staff and the other children, a parent or staff member is stabbed.)
- Natural disasters such as hurricanes, earthquakes, floods.
- Fire in the center or in the home of a staff or family member.
- A child's behavior frightens staff and other children. (For example, a child stabs another child with a scissors, frightening the other children and staff.)

Although Head Start is required to have a plan for health-related crises, it is not required to have plans for mental health emergencies.

discussion of cultural, child development and parenting issues. The partnerships have also worked because the mental health consultants have been willing to enter into the classroom life and to help with the concrete as well as the emotional needs of the families.

The St. Bernard's program is an example of how the provision of intensive mental health services for children and their families under the highest levels of stress can enrich a program. The program knows it can't protect children and families from all the stresses associated with homelessness, such as lack of proper nutrition, the shortage of quality low-income housing in the area, and exposure to community violence. But it does strive to respond to the particular needs of the families, and it provides a measure of stability and support in their too often chaotic lives. With support from the New York State Early Childhood Investment Fund, the mental health consultant, Dr. Paul Donahue, and his colleagues are now developing a mental health consultation workbook, which they are hoping to test in a number of other Head Start and early childhood programs in nearby communities.

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Lessons Learned

- Mental health consultants can play a key role in building staff skills to strengthen relationships among children and families, and help staff cope with difficult issues, such as violence, conflicting views about discipline and troubling behaviors in children.
- Programs report that staff support and mental health-related skill development pay off in multiple ways: better problem-solving skills, greater staff confidence in coping with difficult situations, a wider range of concrete strategies to help children and families, and the provision of a safety valve for staff to enable them to share the frustrations as well as celebrate the victories of their work. All of this can help create and sustain the kind of caring culture that is the hallmark of Head Start.
- Staff support and skill development related to children can take many forms. Programs are using strategies ranging from on-site classroom mentoring, to peer supervision enriched with a mental health perspective, to formal teaching combined with on-site coaching.
- A strong relationship with a mental health consultant provides a context for helping staff plan for and cope with the inevitable crises that will arise.

CHAPTER 3

Creating a Family-Focused Mental Health Vision for Head Start: Building on Family Strengths

All have developed a program-wide strategy and all downplay the use of traditional mental health language and referral strategies. The aim is to bring the families and the mental health strategies into Head Start. As a result, each program is able to provide a welcoming context to families and address often serious mental health issues.

... while mental health professionals were involved in developing the strategies, the actual agents of change are often other parents and/or staff working with the mental health consultants.

Head Start began in 1965 with a commitment not only to children, but to their families, through its strong parent involvement focus, which, at the time, was unprecedented. Head Start was, in fact, an early model for later trends in early childhood programs, such as the recent "two-generation" model, in which services emphasize parents' school and career goals as much as children's development.[35] But as the needs of families have changed, concern has grown that the traditional parent involvement strategies within Head Start no longer have the same impact. Increasingly, the programs are working with families deeply affected by familial or community violence and/or by substance abuse, as well as by deep, chronic poverty. This has led to an effort by many Head Start programs to redefine and intensify their family-focused strategies. In this section, we highlight approaches taken by four programs that seek to reframe their responses to families.

All have developed a program-wide strategy and all downplay the use of traditional mental health language and referral strategies. The aim is to bring the families and the mental health strategies into Head Start. As a result, each program is able to provide a welcoming context to families *and* address often serious mental health issues. Moreover, in another break with tradition, while mental health professionals were involved in developing the strategies, the actual agents of change are often other parents and/or staff working with the mental health consultants.

This is very significant. "Mental health" is forbidding to many Head Start families, as well as to some staff. Some have had prior experiences that were not very successful. Mental health professionals who do not understand a family and a culture's prevailing attitudes and concerns about mental health problems, the stressors that can lead to them, or the methods of coping employed to counter them, can be ineffective at best, hurtful at worst. Some families have had experience with mental health workers trained in "deficit" models of mental illness, in which the causes of psychological difficulties are attributed to characteristics of the families, with little appreciation of the families' strengths or environmental stresses. Deficit-oriented views are particularly problematic when applied to the poor and minority families that make up a large percentage of Head Start families.[36] When families perceive these attitudes on the part of mental health professionals or even Head Start staff, they become (understandably) wary of "mental health," and may shy away from using counseling services or acknowledging a need for them. Sometimes, the prevailing view is that mental health-related activities are

appropriate only for "crazy" people, and therefore have no place in Head Start.

The programs described here, in contrast, integrate mental health services in culturally appropriate ways into the family support system that Head Start offers every day. In Ulster County, New York, supervised social workers and psychology interns from the local community mental health center helped enrich the family-focused mental health services at Head Start. In Cedar Rapids, Iowa, an emphasis on supporting family strengths provided an alternative to the usual problem-centered model of child mental health. In a New York City program (and in the accompanying sidebar describing a Philadelphia program), both generated from Head Start research partnerships, outreach efforts focused on hard-to-engage families and those who had maltreated their children. In Boston, efforts to strengthen mental health focused on enriching in-program mental health expertise and helping staff access formal training.

Using Social Work and Psychology Interns in Head Start/Mental Health Program Collaborations

Ulster County Head Start and Ulster County Mental Health, New York

Many Head Start program administrators now find they simply cannot afford the mental health services their families need. Retaining qualified professionals (especially full-time) has become prohibitive, given limited Head Start budgets for mental health services. In too many areas, especially rural areas, there is a shortage of mental health professionals, particularly those who understand the holistic family focus of Head Start and are experienced in working with ethnically diverse low-income families. One cost-effective way to increase access to mental health services, as well as to increase the pool of mental health professionals committed to the Head Start vision, is to collaborate with mental health programs that offer training sites for the next generation of mental health professionals. While this remains relatively uncommon, and does not always work smoothly, it can have a powerful impact on all participants.

At the Ulster County Community Action Committee Head Start program, based in Kingston, New York, the rising number of stressors on families, including poverty, domestic violence, and crime, have resulted in many children and families being in serious need of mental health services. Traditional mental health services were often difficult for these families to obtain. In addition, as can happen in Head Start programs, mental health care was falling through the cracks. The Family Services/Parent Involvement Coordinator presented these concerns to the Health and Family Services Advisory Committee at the agency, which responded by creating a mental health subcommittee to explore different approaches to providing mental health services to Head Start children, families, and staff. A key member of the mental health subcommittee was the chief psychologist at Ulster County Mental Health Department (UCMHD), who was a longtime member of the Advisory Committee. After a number of approaches were considered and found unworkable, the subcommittee suggested going to UCMHD to see if they would be interested in bringing mental health services into Head Start in

One cost-effective way to increase access to mental health services, as well as increase the pool of mental health professionals committed to the Head Start vision, is to collaborate with mental health programs that offer training sites for the next generation of mental health professionals.

a way that would provide quality programming at minimal cost. The timing was right. The administration of UCMHD was interested in initiating more prevention-oriented activities as well as increasing their outreach to families in poverty; it was a good fit between the two agencies' needs.

The collaboration between Ulster County Community Action Committee (UCCAC) Head Start and the Ulster County Mental Health Department (UCMHD) grew to provide an early intervention program designed to promote positive mental health and to identify mental health problems as early as possible. Ulster County Mental Health Department, as a social work and psychology internship site, was able to provide Head Start with supervised MSW students and doctoral-level psychology interns. The partnership, using the interns, now addresses four major areas: classroom activities, parenting skills/support groups, staff education and support, and on-site individual and family therapy. Both the mental health supervisor and the Head Start program director believe that it is the on-site nature of the program that is key to the positive changes brought about by the collaboration.

The core of the strategy involves having the interns co-lead parent support groups with the Head Start staff. This helped some families who were unable to obtain services from UCMHD for reasons such as lack of transportation and lack of child care. Parents are able to ride in to centers on Head Start buses. Child care is provided during parent support groups so that parents can participate in group sessions without distractions. The strategy also is responsive to the negative feelings associated with needing and receiving therapy. As Head Start family workers and mental health staff model trusting relationships, parents feel more at ease and open to the process of the group experience.

One Head Start mother's experience in the first (pilot) parent group illustrates the effectiveness of the UCMHD/UCCAC Head Start collaboration in developing parents' trust in mental health services. Like many Head Start parents, this mother struggled with multiple stressors. She had a history of poor relationships, some involving violence; she had been abused and had experienced many personal losses. The family, which included two additional children, had seen much hardship, including several moves. The four-year-old Head Start child was demonstrating severe and troubling behaviors, such as head-banging, holding his breath till he passed out, fire-setting, and animal torture. The mother was exhausted, spending most of her non Head Start time at home trying to control her son. It was very difficult for her to ask for help, but with the encouragement and support of her family worker and intern, she slowly began to participate in the group actively. During one group session, another parent reported that her child was setting fires. After the group, the mother described above spoke with the psychology intern, shyly requesting help with her son, who, she reported, was also setting fires.

The psychology intern worked closely with the family worker and the parent to arrange evaluations and, soon after, therapy, which was provided on-site at the Head Start center. In a recent follow-up with the mother, she reported that her son was doing well in school, with his peers, and in his behavior at home. Head Start staff noticed the formerly angry and hostile child was now smiling and skipping when at the center. Additionally, the mother was enrolled in a community college and was to graduate within a few months.

Making Mental Health Family-Friendly

- *Talk with staff and families to understand what (if any) negative perceptions of mental health staff and families hold;* what their prior experiences have been. African American families in one program felt it was only acceptable to use mental health services in extreme circumstances; rural white families in another program reported the same experience. In both, bringing the consultant on-site made a big difference.
- *Avoid using the phrase "mental health" or labels such as "substance abuse,"* when offering services. One program found that a workshop for parents labeled "Substance Free" did not attract a single parent. Others report that the term "mental health" is a turnoff; some avoid the term completely, for instance, calling the mental health consultants early interventionists.
- *Integrate mental health topics into support groups and workshops on more general topics.* Discussions about parenting, life goals, or discipline, as well as staff trainings, are all opportunities to talk about mental health issues.
- *Let parents observe staff-consultant trust in action.* When parents see that staff are comfortable with the mental health consultant, they will become more comfortable with her or him.
- *Ensure that the consultant is on-site frequently enough to become a familiar presence to parents.* Trust is the beginning of a relationship, which opens the door to other changes.
- *Have the mental health consultant co-lead workshops as well as parent groups.* The more parents see consultants working together with Head Start staff, the more comfortable they will become with them.
- *Include explicit support of cultural traditions in efforts to promote wellness and cope with stress in families.* Families bring different cultural expectations to childrearing. Giving voice to these is meaningful to parents and staff alike. The parenting support groups for African American mothers reported in another sidebar in this chapter explicitly encourage cultural expression by group leaders and participants.

The psychologist interns from UCMHD reported that in the early weeks of the parent group, developing trust in the mental health services was crucial. This process was made easier by the parent group meetings, which provided a supportive, nonthreatening environment for the parents to talk about their feelings and the stresses affecting themselves and their children.

The collaboration has recently expanded to include all eight Head Start centers, as well as the home-based program that is also part of the county Head Start program. While a significant focus of the collaboration has been the development of the parent group, the social work students also spend two mornings a week observing children in the classroom, working with small groups, providing individual and/or family therapy, and consulting with teachers regarding the emotional needs of the children. Social work students and teachers plan classroom activities that address issues of self-esteem, appropriate expression of feelings, acceptance of alternative families, and personal safety. The psychology interns also co-lead parent groups and conduct initial assessments.

One challenge that emerged from the collaboration between Head Start and the department of mental health is a concern on the part of some parents that their participation in the support group requires that a case record be opened in their name at UCMHD. Staff of both agencies have been open and honest with parents in discussing this valid concern, and modifications have been made in how charts are maintained.

The collaboration between UCCAC Head Start and UCMHD has brought about improvements in the mental health component of the Head Start program. The eight centers and the home-based program currently receive a total of 90 hours per week from the social work students and psychology interns. Just as impressive, however, is the fact that these improvements come at no cost to Head Start. Ulster County Mental Health Department is an established internship site approved by local social work degree programs as well as the American Psychological Association. The supervisors' time is covered entirely by the agency. (In another Head Start program we spoke with, program funds were used to hire a supervisor for the interns.)

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Linking Families to Each Other and to Other Family Support Programs

Hawkeye Area Community Action Program Head Start, Cedar Rapids, Iowa

A Head Start program in Cedar Rapids, Iowa, has been successful in reversing a traditional view of families as "clients" to families as partners and as leaders. This program, located on the outskirts of Cedar Rapids, mainly serves a European American population, with about 10 percent of its families African American and about five percent Latino. The program had already made considerable efforts to strengthen its family support components, with actions such as lowering the family service worker/family ratio to 1:30 (in many Head Start centers, 1:100 or greater is more the norm) and by enrolling staff in the Family Development Certification program at the University of Iowa. These were key changes in strengthening the preventive aspects of the program: Family service workers were freed up to actually support families, rather than constantly trying to respond to cases or catch up on paperwork.

Program staff also took a look at how they viewed families and discovered that they perceived them as clients rather than as active agents in their own lives. Since that time, staff have deliberately restructured their approach to families, focusing on their strengths as community members, rather than only on their needs as service recipients. This new approach required several steps. First, families were asked what needs they thought Head Start should address. (This was different from the Individualized Family Service Plan

Program staff also took a look at how they viewed families and discovered that they perceived them as clients rather than as active agents in their own lives. Since that time, staff have deliberately restructured their approach to families, focusing on their strengths as community members, rather than only on their needs as service recipients.

familiar to many Head Start staff). Then, staff at the grantee agency compiled the results for each center, and encouraged parent groups to address the main concerns by developing action plans. Four hundred to five hundred dollars were provided to each center to implement the action plan. Parent groups took the lead in the action plans, completing such projects as a child care cooperative, a first aid/CPR workshop, and extending the hours of child care available at the center.

More recently, deliberate efforts have been made to increase the interaction and social networks among Head Start families. A human resource exchange has been started in which families listed resources and skills that they could make available to other families. Using the resource directory, families with a particular need can now identify and get in touch with the appropriate Head Start family. While parent involvement is often perceived as parent involvement with Head Start staff, not each other, this project provides an innovative strategy for increasing the quality of support and interaction among families. Parents are also included in staff training sessions on mental health-related issues, such as child behavior management or aggression. The program places its mental health component in the context of a supportive community in which families can help each other and family strengths are recognized by all staff, rather than a more traditional services model in which families are expected to turn to the professionals for help.

The emphasis on support among families is not made at the expense of staff support. Regular support and learning groups for classroom staff are on-going, not just to sharpen training and skills, but to provide a chance for teaching staff to talk to each other, brainstorm solutions to difficult situations in the classroom, and simply de-brief after their stressful work days. Consultants (usually psychologists from local mental health centers) are invited to discuss special topics, such as acting out or withdrawn behaviors.

The community action agency that funds this Head Start program (HACAP) recently began a transitional housing program called Inn Circle for homeless families waiting for permanent housing. Using the same family focused approach, this program too, has been highly successful, not only in getting families into permanent apartments, but also in supporting parents' work goals while providing high-quality child development programs such as Head Start and infant/toddler care. About 45 families participate. Parents living at Inn Circle are required to work 20 hours a week or go to school full-time. While looking for employment, many parents satisfy their work requirement by volunteering at the infant/toddler center or at Head Start. Mental health-related issues are addressed within a context of family support. Classrooms are organized around daily familiar rituals to provide children with a sense of stability and security. A family support counselor with a degree in social work has her office right next to the two Head Start classrooms, so that she can greet the parents every day. She helps facilitate a Head Start parent-child group, which meets regularly to discuss issues such as the transition into kindergarten and childrearing strategies, and she works extensively with individual parents to bolster their parenting skills and their well-being.

The emphasis on support among families is not made at the expense of staff support. Regular support and learning groups for classroom staff meet, not just to sharpen training and skills, but to provide a chance for teaching staff to talk to each other, brainstorm solutions to difficult situations in the classroom, and simply de-brief after their stressful work days.

Integrating Mental Health with Family Support: Cathy's Story

One mother, Cathy (not her real name) came to Inn Circle after being reunited with her children for the first time in a year. Her three daughters had been taken away from her because of her substance abuse, and the after-care program staff of her treatment center suggested that she enroll in Inn Circle. In the short time that the family participated in the Inn Circle program, they achieved remarkable changes through their work with the family support counselor. The preschool-aged daughter, who had been sexually abused, was very aggressive toward other children when she first came to the Inn Circle Head Start classroom. When not acting out, she would play by herself, refusing to interact with any of the other children. The reassuring daily structure of the classroom, together with extra attention from her teacher, gradually helped her to trust other children and adults. Instead of sitting in the corner and crying, she became able to interact with others.

Cathy joined the program with few parenting skills. She doubted her ability to parent, and felt that it would be inevitable that she give her children back to the state. The family support counselor encouraged Cathy's tremendous desire to learn. Cathy's sessions with her were filled with questions about parenting and about her three daughters. The counselor referred her to a neighborhood support group for parents with children with attention deficit problems, as well as to respite care when she needed it. By the time Cathy left Inn Circle a few months later, she knew how to handle difficult parenting situations and had the confidence to face them. She also had begun to support herself and work on a GED.

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Finding Family Strengths: New Strategies for Family Service Workers

The Head Start Parent Involvement Project, New York City

Head Start parents and staff face a range of stresses every day—from complicated child care arrangements and busy work schedules to the dilemma of how to shield their children from community drug use and violence. Many of them face multiple stresses; it is no wonder that parents in poverty, especially mothers, show high levels of demoralization, depressive feelings, and other needs.[37] Research shows that maternal depression can affect the quality of parenting a child receives and, in turn, that child's mental health, in serious ways.[38]

A research project, initiated by researcher Faith Lamb Parker and her colleagues at two centers in New York City to enhance the extent and quality of parent involvement in Head Start, has in the past few years worked on an area which, at first glance, seems tangential to parent involvement: maternal depression.[39] Parker's previous research had shown, however, that parent involvement in Head Start may reduce the level of depression among mothers.[40] The most recent project employed several steps to develop an intervention to address the needs of hard-to-engage Head Start parents and enhance their involvement. A preliminary survey, designed to assess barriers

to parent involvement, found that the barrier most frequently reported by parents was feelings of depression. As a consequence, the collaborative group of Head Start staff, parents, and researchers involved with the project decided first to learn more about maternal depression and its effects on children and mothers and then to design an intervention that would include attempts to address the problem (the intervention was also designed to address other factors, such as relevant cultural issues in working with minority families in poverty). In the process, it was hoped that the quality of parent involvement would be enhanced, for staff at the Head Start centers in New York City who participated in the project had noted that the "down," depressed parents were the hardest for staff to reach.

The research team and the Head Start staff collaboratively decided to combine its knowledge of the current research in maternal depression and women's development in a new model of training for family service workers. The work of Jean Baker Miller and her colleagues on women's development suggested the benefits of an emphasis on encouraging staff-parent relationships based on mutual, empathic support, rather than the usual "helper-helpee" social services model. Miller's research shows that women develop most successfully "in relation," in networks of empathic relationships.[41] The Head Start research group decided to apply this to the needs of Head Start mothers hardest to engage, including those struggling with feelings of depression such as helplessness and hopelessness. Family service workers were chosen as the target staff due to their ongoing, frequent contact with the Head Start mothers.

After focus group meetings at the two Head Start centers with family service workers and other staff, two strategies were chosen to address the goal of enhancing parent involvement by increasing staff support: (1) a two-day workshop on stress, strengths, and depression among Head Start parents, on understanding parent empowerment, and on strategies to address the stresses facing the most "hard-to-engage" parents; and (2) an ongoing peer support group for family service workers. One part of the workshop consisted of identification of those parents who, in the staff's view, were hardest to engage. These mothers were targeted for increased efforts, using a case management system, to enhance their sense of empowerment and involvement. The ongoing peer staff group addressed both these efforts and the general concerns and issues facing family service staff.

A qualitative investigation of staff perceptions of the effects of the intervention showed increases in parent involvement among most of the parents studied. Here, as at the Hawkeye program, staff at the two centers found it particularly effective to build on strengths; and to address parents' stated goals, meeting them where they were rather than to impose their own goals. One parent stated, for example, that her only goal was to win the lottery. The family service worker was able to establish, for the first time, a productive rapport with the mother by buying her a lottery ticket. This moved the parent to tears, and was key to her establishing a trusting relationship with the family worker. The mother was then able to begin discussing her own goals and dreams, and eventually, she enrolled in a GED program. In addition to these individual successes, the project has also led to a higher level of integration of

The Parent Involvement Project illustrates how addressing the mental health needs of parents can go hand in hand with staff skills development... The Head Start staff participating in the ongoing peer/staff meetings reported that they were valuable as rare opportunities to vent their own stresses, depressive feelings, and concerns in a supportive peer context.

family service workers into all areas of one program site, with individual workers assuming responsibility for education, social services, and family interventions. Family service workers are involved in all team meetings, which are now organized around a case management model, with sensitivity to the mental health and family support needs of families as well as staff.

The Parent Involvement Project illustrates how addressing mental health needs of parents can go hand-in-hand with staff skills development, support for their own professional and emotional needs, and the enhancement of program quality. The Head Start staff participating in ongoing peer/staff meetings reported that they were valuable as rare opportunities to vent their own stresses, depressive feelings, and concerns in a supportive peer context. The approach highlights how interrelated mental health staff-focused and family-focused mental health strategies are.

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Families Helping Families: The Resiliency Partnership-Directed Intervention, Philadelphia, PA

Child abuse is a problem that affects too many families in this country. Research shows that children who have been exposed to physical child abuse are at risk for later mental health problems, such as severe depression or acting-out behaviors. Factors that place parents at risk for physical child abuse include social isolation and stresses associated with poverty. Can Head Start play a role in reducing the isolation of some of these families? John Fantuzzo and his colleagues at the University of Pennsylvania decided to answer this question by developing an intervention, in collaboration with Head Start programs in Philadelphia, that builds on the strengths of resilient families to help more vulnerable families.[42]

The researchers designed their intervention in a true community collaboration—Head Start staff and parents were involved not just in selecting measures for the study but in developing the conceptual basis and components for the program. Together with the researchers they developed a strength-focused model for intervention. At the insistence of the parents, traditional outcome measures were rejected as too negative. Instead, outcomes were defined as positive competencies, rather than reductions in problems.

Head Start parents and children were chosen to carry out the three part intervention. Reach Out, the outreach effort, was designed to bring vulnerable maltreating families into Head Start so that they could gain access to services and support offered there. Using a "village" model, resilient Head Start parents were recruited to accomplish this. Not surprisingly, it turned out that parents were better at bringing in other parents than members of the research team. Then an intensive support strategy, Community Outreach Through Parent Empowerment (COPE), was implemented. This involved developing parent support and education activities for the newly recruited Head Start parents, building social supports among parents, identifying and sharing effective parenting activities, and promoting active parent involvement. The emphasis was on the many positive ways in which low-income African American parents cope with the stresses of their lives. Cultural expression was encouraged, both in teaching style and group member participation.[43] The third component paired up children with acting-out behaviors with trained, "resilient" peers in supervised play sessions.

The intervention was successful in engaging the target parents. Evaluation also showed that involved parents also showed higher levels of support, more contact with other parents, and lower levels of stressors than did control group parents. In addition, children in the intervention went on to show more positive interactive peer behavior, self-control, and interpersonal skills, as well as lower levels of behavior problems, than children in the control group. Both maltreated and nonmaltreated children benefited from the program.

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Enriching In-Program Supervision, Fostering Career Development, and Supporting Consultants

Action for Boston Community Development, Boston, Massachusetts

Action for Boston Community Development (ABCD) has been a Community Action Program in Boston since 1962. It is the grantee for all 18 Head Start programs in Boston, which together serve a culturally diverse group of 2,200 African American, Caribbean American, Latino, and Asian American preschoolers and their families, as well as 100 infants and toddlers at a Parent Child Center. ABCD has developed three strategies that separately and together enhance the mental health skills and supports of the staff: providing supervisors with clinical expertise to family service workers, offering career ladders for staff interested in expanding mental health/family support skills and creating a support network for mental health consultants working in different Head Start programs.

Enriched Supervision

ABCD recognizes the increasing challenges facing Head Start families, which demand much more from family service staff today than they did even 10 or 15 years ago. In particular, the parent involvement and family services coordinator and the mental health coordinator shared a concern that mental

The Positive Effects of Hiring a Social Service Supervisor with Mental Health/Clinical Experience

The use of on-staff master's-level social workers to supervise family services staff has made a difference in the program staff's response to families. In one case, a supervisor had extensive experience working with domestic violence issues. One of the families involved in the Head Start program had a four-year history of domestic violence. Although the couple did not want to split up, the mother was concerned about their child's behavior problems and related them to the violence. The supervisor had started a parent support group at one of the ABCD centers, and invited this mother to join the group. Her participation in the group increased her level of trust, and eventually drew her into family counseling with the supervisor. With this support, the mother felt confident in telling her partner to leave their home while they resolved their problems.

This supervisor not only works directly with families through the support group and family therapy, but also has led domestic violence workshops for staff. These workshops have been very well received, since staff respect her level of knowledge and experience with the issue. Moreover, the supervisor is not from an outside agency, but was hired by Head Start administrators, an advantage that eases the process of integration with other staff.

The issue of child abuse has also been addressed by the supervisors at ABCD. Staff maintained a conscientious effort to file reports when they suspected abuse; however, they had never coupled this action with deliberate strategies to help the families with childrearing. Guided by clinically-informed supervision, staff are now helping families deal with difficult issues around parenting. Parents are encouraged to attend support groups and then, as they build their skills and the danger of abuse diminishes, to volunteer in the classroom to learn from teachers who work with demanding children. Further, providing a supervisor with mental health skills has also made it possible for staff to focus more openly on cultural differences among families in parenting, especially discipline practices .

health problems were becoming worse among the Head Start families. In response, they created the position of social service/mental health supervisor, who is responsible for several sites and provides on-site clinical supervision, training, and support to family service staff. This person also supervises local social work interns, who work closely with the family advocates. (Pairing the interns and the family advocates is deliberate. ABCD found that the social work interns learn from the advocates about the families and communities, and the advocates feel energized by the students.) The initial impetus for this strategy of strengthening the in-house clinical capacity came from pooling regular Head Start funds with money from a one-time grant to support a Family Services Center. In the current year, there are four of these supervisors; their positions have been paid for by combining dollars allocated for social services and mental health and upgrading a number of family service coordinator positions. ABCD's ability to pool its funds in this way also illustrates the flexibility a grantee has, an advantage over any single site's ability to fund a clinical position such as this. The mental health coordinator emphasizes, however, that a smaller grantee could also fund a social service/mental health supervisor by using program improvement money for that purpose.

Career Ladders

Viewing the family service workers as the backbone of Head Start's preventive services, ABCD has also developed, in conjunction with Peat, Marwick and Mitchell, a career development ladder for them. The ladder provides a progression of skills and qualifications in the family services component, from entry level paraprofessional with a GED to licensed social worker with an MSW. Each step has additional education, training, salary compensation, and limits. The career ladder includes small, realistic increments, so that a family service worker need not wait until he or she has earned a bachelor's or master's degree to receive salary increases related to the increased mental health skills. The ongoing mentoring by the social services/mental health supervisors has also helped to motivate family advocates to take courses to further their careers, as they realize the benefits of additional mental health training.

Making further training available to Head Start staff at ABCD is facilitated in two other ways as well. First, the Head Start staff have ready access to formal courses. ABCD is unique among Community Action Programs in having the Urban College of Boston, which specializes in the fields of education and human services, as part of the organization. The college, which fills two floors of the ABCD building, provides on-site adult development and social work courses, not only to Head Start staff but to Head Start parents. The Human Services track in their program includes social work courses, with training on basic interviewing and counseling techniques, family mental health, and case management. One family advocate has gone on to finish her BA, with another finishing in a few months. In addition, social work supervision consultation is offered on-site for family advocate supervisors to assist with difficult problems. The mental health coordinator reports that the family services staff at the programs has become professionally richer and deeper, providing better services to meet the needs of program families.

The career ladder includes small, realistic increments, so that a family service worker need not wait until he or she has earned a bachelor's or master's degree to receive salary increases related to increased mental health-related skills.

The second approach ABCD uses to facilitate career growth and development is by designating a Family Service Employment/Training Coordinator to help Family Advocates develop individual training plans and track their progress. The coordinator also helps Family Advocates with obstacles and provides appropriate intervention or referrals when needed. While training efforts on this scale may be difficult at the individual program level, the kinds of linkages that ABCD has forged with a training institution and the commitment to staff development and enriched supervision could be carried out by smaller programs.

Supporting Staff Career Development in Mental Health and Family Support: Family Development Specialist Credentialling

One way to ensure that staff interested in mental health and family support receive both training in supporting families and recognition for such training is through a certification program in family development and family support. There has been a certification program in early childhood education, known as the Child Development Associate program, since 1972. Through that program, over 350 local junior colleges, colleges, and universities have provided training in early childhood education to over 20,000 Head Start and other early childhood program staff.[44] There is, however, no equivalent credentialing system for staff interested in mental health/family support.

Like ABCD, the National Resource Center for Family Centered Practice has also developed an entry-level Family Development Specialist certification program which is used extensively among the entire early childhood community in Iowa (including the Hawkeye Area Community Action Head Start program, profiled in this chapter). The response to the certification program has been so positive that training is being extended to elementary school staff, public health nurses, human services staff in other states, and welfare recipients in job training programs.

Training as a Family Development Specialist takes place over eight days, usually spread out over a couple of months. The focus is on increasing knowledge about family dynamics and about how to create trusting, open collaborative relationships with families. Topics covered in the training include family structure, dynamics and the family life cycle, techniques of assessment tailored to the whole family, case planning and management, ethics, problem-solving, and a series of special topics including depression, substance use, domestic violence, and child abuse. The program does not require prior experience in family support or mental health.[45]

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Helping Mental Health Consultants

The ABCD strategies just described focus on support to Head Start staff working with families. To provide mental health services to children experiencing the most difficulty, ABCD had, at the time of our visit, begun to contract with neighborhood health services. To facilitate the work of the mental health staff from the neighborhood health centers, the ABCD mental health coordinator (who is also the special education coordinator) planned to convene periodic meetings of all the mental health staff from all the neighborhood-based centers and to use this informal brown-bag setting as a vehicle for training, problem-solving, highlighting unmet needs, and whatever other issues the consultants wished to explore.

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Lessons Learned

- On-site, family supportive, nonstigmatizing services are less threatening than the usual referral for therapy. Parent support groups, for example, help families feel more comfortable asking for help, sometimes increasing their willingness to use more traditional mental health services if they need them. Linking parents with family support programs, either by bringing them on-site or making them accessible to parents, or building parent-to-parent support within Head Start, can help families connect with others at the same time they address their own issues.
- Family-focused mental health strategies in Head Start need to address the community and cultural meanings of mental health. Sensitivity to the community's attitudes, strengths, and resistances to mental health services requires a willingness on the part of the involved mental health consultants and agencies to revise and adopt strategies to best fit the families served by the Head Start program.
- On-site, strength-based, family-focused, mental health strategies require a shared vision that takes time to develop. They may also require a shift in how staff perceive families, their strengths, and what their lives involve.
- Family-focused mental health strategies in Head Start cross sometimes rigid boundaries between mental health, family service, and parent involvement components. Programs report that mental health strategies that start where families are seem to have significant payoff, but using family-centered service strategies takes a lot of staff- and director-level support.

CHAPTER 4

Building Community Strategies for Mental Health

Most of the Head Start efforts to improve mental health are program-focused, carried out in the context of the program, often in partnership with one other agency. But some programs are also reaching out to link with broader community initiatives either to better serve the most troubled children and families, or to engage in community building, prevention oriented efforts. This chapter highlights three strategies: "system-of-care" initiatives focused on the most troubled children and families, service integration efforts focused around family resource centers, and prevention efforts focused on mobilizing communities to address risks, in addition to helping individual children and families.

"System-of-care" approaches to children with challenging emotional or behavioral problems until recently have been applied primarily to older children and their families, typically those at risk of out-of-home placement.[46] These initiatives are marked by several defining characteristics; they are family-focused, families are viewed as partners with the treatment team, service dollars are used flexibly to meet family needs, there is a mechanism for multiple community agencies (including, for example, recreation agencies as well as traditional mental health agencies) to work with individual families, and there is a governance mechanism (typically with family members as well as service providers) to address system-level issues.[47] Service integration efforts share the same family-focused, strength-based values, but do not identify a target population, and may involve more community-based organizations. Comprehensive prevention programs define another community-wide mental health strategy. Increasingly, prevention programs addressing problems like delinquency, substance abuse, and AIDS often incorporate not just individual, family-, and school-focused components, but also community-wide activities such as media campaigns, community organizing, and use of opinion leaders respected in the community. These supplement traditional classroom-based prevention curricula, workshops, and services for parents and children. Most importantly, community leaders and residents drive the efforts.[48]

The three programs that we highlight in this section illustrate these approaches. The Stark County, Ohio Head Start, is adapting the system of care concepts to its early childhood mental health approach.[49] The Hawkeye Head Start program (which was highlighted in the last chapter) is highlighted here because of its involvement with a community-based services integration initiative anchored in a family resource effort. The Colorado Springs Head Start is involved in a community organizing effort designed to address

substance abuse issues. Linking with the broader community has of course, been central to Head Start throughout its history, particularly through its early roots in neighborhood-based Community Action Programs.[50] The growing recognition, grounded in empirical studies,[51] that there are real effects of neighborhoods and communities on mental health outcomes for children and families provides a strong rationale to increase the community-linked focus to both respond to and prevent the complex problems that so many Head Start families face.

Using a Children's Mental Health System-of-Care Approach

Stark County Community Action Agency Head Start and the Child and Adolescent Service Center Preschool Community Services Program, Stark County, Ohio

Stark County, Ohio, is known as one of the leaders in implementing a family-centered, cross-system approach to children with serious emotional and behavioral disorders. It has created a governance infrastructure to enhance a family-focused, flexible service delivery system for all children and families (originally, the focus was only on the most troubled children who used resources from multiple systems), and it has transformed a traditional mental health system into a network of flexible family-focused mental health services.

The community decision making structure, of which the Head Start director is a key member, is known as the Family Council. The Council provides a community-based mechanism for cross-system planning and problem solving among public systems and private agencies, oversight of the allocation of funds, including blended public funds, and ensuring that families have a voice in the service delivery system. The council has reduced costs of out-of-home and psychiatric placements, created a range of innovative new services, including a mobile early childhood unit, and seeded Creative Community Options, a mechanism for individual cross-agency case planning with families. Members of the Family Council governing board include public county and city schools, health agencies, county child welfare and mental health agencies, representatives of a newly formed family advocacy organization as well as the director of the Stark County Head Start. A 37-member group known as the Working Council on Young Children was recently constituted to improve outcomes for young children and families. This group works in tandem with the service agencies in the county.

In adapting the mental health system-of-care service strategies to a younger population, the Child and Adolescent Service Centers (CASC), the county mental health agency, has taken the lead. The first step has been the creation of an on-site Head Start Mental Health Team. The Center originally used its mental health dollars targeted to young children for a therapeutic nursery school/day treatment program for children from five to eight. Then, concerned that the children showed gains in their behaviors during program hours, but not at home, the Center staff created an alternative service, the Preschool Assertive Community Treatment Program (PACT). PACT provided intensive, in-home, and other support services to families with young children (including

The System-of-Care Approach in Action: Jasmine's Story

Jasmine, a four-year-old child in the Stark County Head Start program, illustrates the power of an intensive intervention for a child who seemed clearly headed for serious problems, and a family on the verge of disruption. Jasmine was a source of great concern to her teachers. She fell on the floor when corrected, ran in and out of classrooms, became involved in frequent fights and sometimes even urinated in the halls. Her mother, a single parent with an 18-month-old son, had recently returned to school. She felt totally overwhelmed, and was tired of being told about her daughter's problems. Jasmine was assigned an Early Childhood Interventionist (ECI) from the CASC mental health team about halfway through the year. Initially, although the interventionist visited the home, the mother did not want help, saying Jasmine was not a problem at home. The ECI worked with Jasmine and her teacher in the classroom, at least three times a week. She also requested a classroom-based consultation with a child psychiatrist from the Child and Adolescent Services Center. Jasmine's mother then agreed to have the psychiatrist visit her home. This was a turning point. The mother found the psychiatrist's concrete suggestions very helpful. The ECI was able then to ask the mother what else she thought would be helpful. Overwhelmed by the demands of an infant, a very challenging preschooler, a job, and an attempt to take a course, the mother said she needed some uninterrupted time to study. The ECI suggested that the mental health team, as part of the treatment plan, provide an evening in-home respite worker three nights a week. This in-home aide, paid for with flexible mental health dollars was able to carry out some specific treatment plan objectives (modelling different ways to respond to Jasmine's demands), and, at the same time make it possible for the mother to do her school work. The ECI also arranged for the mother to become part of a parent support group. Gradually, as Jasmine's behavior improved, the mother felt less stressed, the ECI was able to cut back her time in the home, and reduce the hours of the night time respite worker.

Jasmine's story illustrates how access to intensive, flexible and comprehensive services within Head Start can help Head Start meet its program goals and help even the most overwhelmed families. The stresses of Head Start families rarely fit into a single, narrow category—just a child care problem, just a mental health problem, or just a child protection problem. More commonly, stresses and problems cross boundaries. Through the early intervention team, and the use of mental health service strategies emerging from the children's mental health reform movement of the past decade, Jasmine's mother was supported in her parenting and her quest for self-sufficiency. An intensive intervention turned around a situation that easily could have escalated into an out-of-home placement. Instead, with a strategic investment of dollars, Jasmine and her mother are now on the way to a healthier and more productive relationship.

those under five). In the PACT model, early childhood interventionists (ECIs), professionals and paraprofessionals were trained to provide a listening ear, defuse crises, and provide support services and case management. Supervised by CASC's clinical supervisor, the ECIs worked with not only the children, but the parents, providing home-based parent education and child development information, as well as help with behavior problems. They also provided consultation to child care providers if appropriate. Coincidentally, shortly after PACT was developed, the Stark County Community Action Agency became the new Head Start grantee. Recognizing the power of the PACT model, the designers built into that initial proposal a strong and innovative mental health component, adapting the PACT teams to the Head Start context.

Today, a community-based team of professionals and paraprofessionals supervised by the program coordinator and a clinical supervisor of the mental

health agency provide on site consultation and services to Head Start children, families and staff. If necessary, consultation with a child psychiatrist and psychiatric nurses is available. The on-site team has access to all the supports that a system of care can offer, including flexible funds for services to help families with very troubled children. In additional to traditional Head Start mental health activities such as classroom observation and consultation, the team makes home visits, works with parent groups, helps with case management, provides access to psychological assessment and psychiatric consultation, and offers "wraparound" support, including respite care. (In mental health, wraparound support means in-home or other flexible support that is offered pursuant to a clinical treatment plan. It does not mean, as it does in the early childhood community, linking half-day programs with full-day child care). A team of three early interventionists, two full time and one part time, are available to work at the eight SCCAA Head Start sites. The team also organizes training for the Head Start staff on such topics as behavior management, classroom transitions, stress management, and the entry of Head Start Children into kindergarten. The Child and Adolescent Service Center pays 50 percent of the costs of this special team, Head Start the remainder.

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Head Start, Family Resource Centers and Service Integration

Hawkeye Area Community Action Program Head Start, Cedar Rapids, Iowa

The Hawkeye Area Community Action Program (HACAP) Head Start program in Cedar Rapids, Iowa, has already been noted (see Chapter 3) for its emphasis on supporting family strengths. The HACAP Head Start program is also part of two linked community-building initiatives.

The first initiative involves a service integration strategy. Several years ago, a collaboration was formed among five agencies that offered both child development services and family support services in order to improve and integrate services to children and families in the Cedar Rapids area. The five agencies were HACAP (including the Head Start program within HACAP), the YWCA, a local community house with roots in the settlement house movement, a foster care and family therapy agency, and a visiting nurses

In addition to co-locating services, the FRC's plan to serve as the base for interdisciplinary teams, made up of a DHS social worker, a public health nurse, a Head Start family services worker, and a child abuse assessor. The aim is for the teams to maximize the impact of informal supports, as well as traditional services for families under high levels of stress, and to strengthen the focus on prevention and early intervention.

association, representing a health perspective. Staff from these five agencies formed a Resource Development Association which they hoped would become a vehicle not just for co-locating services, but for developing a truly coordinated community response to the needs of families.

As the collaboration proceeded, other agencies became interested and eventually, close to 30 participated in the establishment of four Family Resource Centers (FRCs). Both private nonprofit organizations as well as public agencies, such as the local Department of Human Services, Department of Health, school districts, and local community mental health centers were involved. Together, the agencies developed a plan for core services at each of the Family Resource Centers: Head Start or a state-funded child development component, scheduled child/maternal health and WIC clinics on-site; a family support component; an office for DHS and income maintenance staff; and space (that included a washer, dryer, and phone) for families to relax and network. Currently, the four FRCs are at various stages of development, with one fully operating. Three of the four centers have a Head Start classroom on-site.

In addition to co-locating services, the FRC's plan to serve as the base for interdisciplinary teams, made up of a DHS social worker, a public health nurse, a Head Start family services worker, and a child abuse assessor. But these are not to be traditional formal service teams. The aim is for the teams to maximize the impact of informal supports, as well as traditional services for families under high levels of stress, and to strengthen the emphasis on prevention and early intervention. One such team is already functioning. In particular, there has been a focus on the prevention of child abuse. This has already affected the service delivery approach of some of the systems represented. For example, through the participation of the child abuse assessor in the FRC, the approach to child protection has expanded from a sole focus on investigating suspected instances of child abuse to preventing child abuse among families under high levels of stress.

HACAP Head Start is also part of an effort to encourage neighborhood associations, which have traditionally not focused on human service issues, to link more closely with the FRCs at the governance and at the service level. The former is accomplished through involving community leaders who are also active in their neighborhood association on the governing councils of the FRCs.

Using Neighborhood Supports: Anna's Story

One young mother's story, Anna, illustrates the way that neighborhood partners build connections with parents. This mother had been referred to a neighborhood partner when a child abuse assessor sensed that she was under extremely high levels of stress and was visibly depressed. She had recently undergone treatment for a severe substance abuse problem, and as part of her recovery decided to leave her old neighborhood and its drug trade to move into a new one (which had an FRC within it). The mother felt very isolated in her new neighborhood, and feared that she would go back to relying on substances to cope with her stress. The neighborhood partner gently engaged her, building her trust and eventually Anna decided to participate in both neighborhood meetings and the FRC. Feeling more connected, she began to feel more hopeful, and to cope more effectively with the continuing stresses in her life.

At the service level, each FRC model identifies neighborhood partners, "mentor" individuals in the community who are respected as natural leaders. These neighborhood partners are trained to provide referral information and informal support to families under stress, to link families with the FRCs, and to help isolated families build connections to other families and to needed services. The neighborhood partners are supervised at each site by family support workers, charged to both train the partners and to work themselves with up to 20 families. These neighborhood partners are seen as key to reaching out to families and fostering informal social support networks.

The Family Resource Center project is funded mainly through a cost-sharing agreement among the 30 agencies in the partnership. In addition, a portion of the money is available through an innovative funding arrangement, which allows for state child welfare money not used in meeting treatment costs to be carried over from year to year and used for preventive activities. Finally, the Edna McConnell Clark Foundation funds additional family support workers at each FRC and has provided for a self-evaluation component. A tracking system for the family support component has been created, and measures are currently being developed for evaluation.

Fighting Substance Abuse

Free to Grow and the Community Partnership for Child Development Head Start, Colorado Springs, CO

The impact of substance abuse on families can be devastating. When it occurs through direct involvement of a family member with alcohol or drugs it can fundamentally change a child's world. Sometimes, given that substance abuse is a primary risk factor for HIV infection and AIDS, intravenous substance abuse can destroy families. Yet, although many Head Start families are directly affected by substance abuse, often they are reluctant to reveal that they are in some way struggling with substance use problems. Staff too are reluctant to identify families as involved with substance abuse, even when the evidence is clear. (Head Start family services coordinators report concern, for instance, that their home visitors are ignoring unmistakable signs of heavy alcohol use.) Further, even if there is no familial use, high levels of community abuse and or dealing affects the quality of community life. This too, takes its toll on Head Start children and families as well as on staff.

The Free to Grow: Head Start Partnerships to Promote Substance-free Communities is a national demonstration project funded by the Robert Wood Johnson Foundation.[52] Its goal is to help Head Start programs address the problem of substance use, both within families and at the community level. Each of the five Head Start programs chosen for the demonstration (funded by the Robert Wood Johnson Foundation) is charged with developing a plan to address substance use through both community organizing and working with families.[53] Free to Grow's approach is an example of recent comprehensive models of substance abuse prevention that incorporate not just individual, family, and school-focused components, but also community-wide activities, including partnerships with a wide range of community agencies and leaders.[54]

The Community Partnership for Child Development (CPCD) Free to Grow program's community organizing activities have consisted of creating a neighborhood family council, made up of Head Start parents, other residents, and community leaders from local police, school, mental health, health, and youth services, as well as the local Urban League. The mental health coordinator noted that setting up the family council had gone smoothly and that "the neighborhood has trusted us quickly because of the Head Start model."

For the Free to Grow effort, an evaluation of the planning process of the programs in the first year of the project revealed that four main strategies were being used: increasing parents' access to information and knowledge about substance use and related issues; supporting families by linking them with either peer mentors or institutions; increasing access to needed services; and establishing a forum for local residents to come together to identify community needs and formulate and implement strategies to address them.

The Community Partnership for Child Development (CPCD) Head Start project, in Colorado Springs, Colorado, is one of the five demonstration sites of Free to Grow. The community of Stratton Meadows, in which the Head Start center is located, is predominantly European American (73 percent), with substantial Latino (23 percent, of all races) and African American (10 percent) communities. The CPCD estimates that half of its Head Start families have drug- and/or alcohol-related problems. Gangs involved with the drug trade have been responsible in recent years for a surge in the number of violent crimes committed by youths.

The program, in keeping with Free to Grow's dual emphasis on outreach to families and community organizing, has initiated activities in both areas. A contract with a substance abuse treatment center has resulted in two substance abuse counselors acquiring full-time positions devoted entirely to the 600 or so Head Start families (a third position is about to be funded, through an expansion grant). These family counselor positions are funded entirely by Free to Grow. Echoing their experience with the term mental health, although the position was initially named "Substance Abuse Counselor," the program staff found out quickly that this title was stigmatizing to the families, and therefore changed it to "Family Counselor." The family counselors engage in direct services to families (counseling an abuser or working with other family members or both). The counseling sessions occur at the Free to Grow office (which is a block away from the Head Start centers), or, if families prefer, in their own homes. The counselors' willingness to go to the families' homes respects family concerns about confidentiality; in fact, the majority of the families seen during the first year of the project were seen in their homes.

The family counselors train both staff and parents about substance use and its effects on families, parenting, and children. But just as programs have found it wise to avoid the term mental health, so too, substance abuse can turn families away. One of the advocates told us that initially she had titled a workshop "Substance Free." Not a single parent showed up to the workshop meeting. The counselor, realizing the threatening nature of that title, integrated subsequent trainings into existing workshops for parents and staff, offering information on such subjects as signs of substance abuse, alcohol abuse, and inhalant abuse (which is prevalent in this particular community), and the relationship between substance abuse and domestic violence. The family counselors, in collaboration with Head Start staff, also develop trainings on related issues such as stress management, anger control, and parenting of teenagers.

When serious problems arise, and a referral to more formal substance abuse treatment is required, the families can go to a specific therapist at the local substance abuse treatment center whose work is devoted to Free to Grow

Building Trust: Working with a Mother Involved with Substance Abuse

There are special challenges in working with families involved with drugs or alcohol. The family members directly involved may be very unwilling to accept help; other family members may also not wish to face the problem; and every member of the family is affected, including children, who may be at higher risk of neglect or abuse due to the substance abuse.

One Free to Grow family's story illustrates both the challenges and rewards in helping a family face the problem of substance abuse. Linda (not her real name) was the mother of four children, including one in Head Start. She had a problem with drugs and alcohol, and often spent her days on the street in her neighborhood. When the neighborhood family advocate (NFA) first met her, she did not trust either her advocate or Free to Grow, and was extremely reluctant to reveal anything about herself or her family. But she was motivated to improve her parenting; she had once been involved with the local Child Protective Services after she had left her children alone for an entire night. Gradually, the advocate built up a relationship of trust, by getting to know her, talking to her, and visiting her in her home and neighborhood. She also let her know of the range of services she could offer her, in particular the parenting classes which were available at the Head Start center (which, in this neighborhood, is housed in a comprehensive family resource center, with a WIC office, a food bank, and other services). Linda eventually accepted the offer to attend a parenting class. Having taken this first critical step, she began to attend other classes and also agreed to see a therapist at the local clinic, who helped her with both parenting skills and substance abuse issues. Linda's children had shown a range of acting-out behaviors—the Head Start teacher was concerned that Linda's child was endangering the other children in the classroom with his fighting. The therapist helped Linda to be consistent with her children and to feel comfortable being in control of them. Most importantly, the therapist helped Linda stop using drugs and alcohol.

Linda is now very involved in local community activities. The neighborhood family advocate proudly said that Linda has become an outgoing person, who has learned an entirely new way to talk and interact with others. Her children are now showing much lower levels of emotional and behavioral problems. She credits the changes in Linda's family to the gradual process of building a trusting relationship, including her involvement in non-threatening parenting classes, which served as an "icebreaker." On-going support provided on-site in the home and neighborhood, was crucial to convincing Linda that she and her family could change.

families. The families from Head Start can access free services at the center through this therapist, and bypass the waiting list (such lists are usually major obstacles to people who seek treatment for substance use problems).

In addition to the family counselors, a neighborhood family advocate position was created as an extension of the regular Head Start family service worker. This position provides for a neighborhood-based resource and referral person who also conducts community-based parent education and support groups, and facilitates the community development activities of Free to Grow. Unlike the family service workers, the NFAs target families before their children attend Head Start, and after they have left the program. The NFAs live in the community, and are thus able to identify earlier the families at highest risk for problems with substance abuse. They also encourage these often isolated families to participate in the community strengthening activities of the program.

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The CPCD Free to Grow program's community organizing activities have consisted of creating a neighborhood family council, made up of Head Start parents, other residents, and community leaders from local police, school, mental health, health, and youth services, as well as the local Urban League. The mental health coordinator noted that setting up the family council had gone smoothly and that "the neighborhood has trusted us quickly because of the Head Start model."

Similarly, the Head Start parents on the council were accustomed to the degree of parental advocacy and involvement in Head Start, and were thus comfortable engaging in community activism. A neighborhood family advocate reports that as parents become involved, they learn that they have a voice in the community and can bring about positive changes. This in turn increases their sense of ownership of their community and raises their self-esteem and confidence when relating to other residents.

The neighborhood family council has given rise to three action groups devoted to community safety, school-community relations, and community activities. The community safety group has addressed neighborhood features that affect substance use, such as a liquor store that opened at seven in the morning, supermarket tobacco vending machines, improving lighting in the community, park upkeep, and graffiti removal. The school-community relations group dealt with such issues as keeping schools open after hours for youth activities. Finally, the community activities group has planned neighborhood block parties and other community-wide social events, offering information on services as well as entertainment, food, and drink.

By addressing the problem of substance abuse at both the family and community levels, the CPCD Free to Grow program approaches the comprehensiveness of some of the more effective substance use prevention programs. Although the evaluation of prevention outcomes in Free to Grow is just beginning, such programs hold great potential to increase Head Start's responsiveness to substance abuse, not just in its own centers, but in the communities it serves.

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(719) 635-1536
Contacts: Terry Schwartz, Assistant Director
Rebecca Stocker, Family Services Coordinator
Dorothy Madre, Free to Grow Neighborhood Family Advocate

Lessons Learned

- Organizing communities to address problems can be an effective component of Head Start's efforts to deal with seriously troubled children and families with severe challenges, such as substance abuse, as well as provide a welcoming network for families struggling with the everyday challenges of childrearing, compounded by poverty.
- Although six of the 14 programs profiled in this paper report collaborations with local community mental health centers, only two describe serving the most seriously troubled children using community-based system-of-care principles. Additionally, only one reported using neighborhood organizing to complement more direct work with substance abusing families (and that one was a result of a foundation-supported initiative).

CHAPTER 5

Addressing Mental Health Needs in Head Start: Special Challenges

The programs profiled in the previous sections illustrate three central (often overlapping) approaches to improving the integration of services and mental health services in Head Start: child focused, family focused and community focused strategies. There remain, however, many specific mental health-related challenges that have not been discussed. This section considers four: (1) identifying children with, or at risk of developing, emotional and behavioral problems; (2) using research to improve mental health in Head Start; (3) financing mental health services and strategies; and (4) developing national training and technical assistance strategies.

Identifying Children with Emotional and Behavioral Problems

The Early Screening Project

Recently promulgated Head Start Performance Standards place strong emphasis on Head Start's obligation to provide appropriate developmental, sensory, and behavioral screenings of Head Start children. This means that now, more than ever, Head Start needs tools to help programs provide accurate, valid assessments for emotional development and mental health-related problems.

Such tools are also necessary to help Head Start address a long standing problem; the under identification of children with emotional and behavioral disabilities. Data from the 1994/1995 year, revealed that 12.9 percent of children enrolled in the program were professionally diagnosed as disabled (105,877 out of 818,769 children enrolled).[55] Of these children, 5,430, or about two-thirds of one percent of the total Head Start population, were diagnosed with an emotional or behavioral problem, making up about five percent of the Head Start children diagnosed with disabilities. In contrast, a recent study carried out by Sinclair and her colleagues in California, using careful assessment procedures for emotional and behavioral problems, found that emotional and behavioral disorders were the most commonly diagnosed type of disability, comprising 29 percent of all children diagnosed.[56] (As noted in Chapter 2, Webster-Stratton and her colleagues found that 16 percent of all children in a sample of Head Start centers showed behavior that was clinically problematic.) Other estimates, focused not just on the Head Start population suggest that anywhere from seven to 25 percent of preschool children meet the diagnostic criteria for conduct disorders.[57] Sinclair also found a significant proportion of the children who had emotional and behavioral disorders as

Head Start Screening Requirements

(Excerpted from the Federal Register, Vol. 61, No. 215, p. 57212; See Appendix C 1304.20 Child health and developmental services)

(b) *Developmental, sensory, and behavioral screening.*

Requires:

- Within 45 days of each child's entering the program, and in collaboration with parents, agencies must perform linguistically, culturally, and age appropriate developmental, sensory, and behavioral screenings of motor, language, social, cognitive, perceptual, and emotional skills.
- Agencies must obtain guidance from a mental health or child development professional on how to use the findings to address identified needs.
- Agencies must include multiple sources of information on all aspects of each child's development and behavior, such as input from family members, teachers, and relevant staff.

their primary problem had in fact been identified as having speech and language impairments.

These findings, which are consistent with reports that we heard, are troubling for several reasons. First, if children are misidentified, or not identified as in need of help, they will either not get any help, or they will not get appropriate help. Since early onset problematic behavior, particularly aggressive behavior, is predictive of long term and often high cost problems, this has fiscal implications as well as implications for child and family functioning.[38] Second, when teachers have several children who are at high risk of developing, or already showing signs of problems, it affects the quality of classroom interactions, sometimes eliciting responses from teachers that may only make the situation worse. Thus it is important to pay attention to signs of emotional and behavioral problems in children both to get the right kind of help to the children and families (See Chapter 4) and to help teachers be more effective working with such children, either in the context of special help for them, or interventions targeted to all children and families in Head Start. (See Chapter 1 for examples of the latter.)

One initiative tackling the problem of helping teachers identify children at risk of developing emotional and behavioral problems is the Early Screening Project (ESP), which over the last five years has developed a validated and easy-to-use strategy for assessing existing emotional and behavioral problems among preschool children. Edward Feil of the Oregon Research Institute, together with Hill Walker, Herbert Severson, and Wesley Becker, has modified an instrument originally developed for use by teachers of elementary-school-age children for use with preschool children.[39] That instrument, the Systematic Screening for Behavioral Disorders (SSBD), is comprehensive: it screens not only for the acting-out behaviors that represent the most intrusive mental health problems for teachers, but also for withdrawn behaviors.

The Early Screening Project instrument is very much like the SSBD. It is made up of three parts, two involving the teacher, one, another observer. In the first part, the teacher ranks the five children in his or her class who exhibit the most acting-out behaviors, and the five who exhibit the most withdrawn behaviors. In the second part, the teacher fills out a questionnaire on specific

Head Start Criteria for Identifying Children with Emotional and Behavioral Disorders

On January 21, 1993, Head Start published regulations outlining the criteria for identifying children with emotional or behavioral disorders. They state:

A child is classified as having an emotional/behavioral disorder who exhibits one or more of the following characteristics with such frequency, intensity, or duration as to require intervention:

- Seriously delayed social development, including an inability to build or maintain satisfactory (age appropriate) interpersonal relationships with peers or adults (e.g., avoids playing with peers);
- Inappropriate behavior (e.g., dangerously aggressive towards others, self-destructive, severely withdrawn, noncommunicative);
- A general pervasive mood of unhappiness or depression, or evidence of excessive anxiety or fears (e.g., frequent crying episodes, constant need for reassurance); or
- Has a professional diagnosis of serious emotional disturbance.

In addition, the rule requires that "the eligibility decision be based on multiple sources of data, including assessment of the child's behavior or emotional functioning in multiple settings," and that it "include a review of the child's regular Head Start physical examination to eliminate the possibility of misdiagnosis due to an underlying physical condition." (*Federal Register*, 58, 12, 21 January 1993: 5506).

behaviors of those ten children. The third part requires observation of the ten children both on the playground and in the classroom; this observation may be most appropriately completed by the mental health coordinator or a mental health consultant.[60] Thus, the assessment is comprehensive and includes information from two different sources: the teacher and an independent observer.

The screening was designed so that the teacher's assessment (the first two of the three parts) of his or her entire classroom could be completed within an hour. Children identified through the assessment as having particularly severe problems may then be assessed for diagnosis individually by the program's mental health consultant. The screening tool has been used at Head Start centers in California and Texas, and has been found to be valid, not only when compared with other established assessments (most of which take longer to administer) but in predicting which children teachers identify as requiring help for behavior problems.

Staff also find it user-friendly.[61] One Head Start director of a program in rural Minnesota which is receiving training to use the ESP, reports that her staff have been positive about the length and simplicity of the measure. At this site, the ESP will be used to supplement the anecdotal observations of the mental health consultants who have been contracted to do classroom observation. The director expects that the tool will increase the credibility of Head Start staff when they make referrals to the local school-based early childhood special education programs for children showing behavior problems (in some cases, referrals from Head Start had been greeted with skepticism about the ability of Head Start teachers to assess children). The ESP thus may make a difference in obtaining timely referrals, diagnoses, and follow-through for Head Start children showing behavioral and emotional

Other Assessment Tools

Another assessment tool being tested on the Head Start population is the Preschool Symptom Checklist. This short checklist, which has been developed by Dr. J. Michael Murphy is also easy to administer; and is currently being field tested in Ventura County, California. Evaluators are studying its efficacy as a tool that can be used for EPSDT (The Early Periodic Screening, Diagnosis and Treatment Medicaid program for children) to help screen children with emotional and behavioral problems. (Although this measure is not yet widely available, for more information contact: J. Michael Murphy, Ed D., Massachusetts General Hospital, Child Psychiatry Service, ACC 725, Boston, MA 02114). The Preschool Socioaffective Profile has also been validated on a Head Start population, but that measure takes substantially longer to complete than either the ESP[62] or the Preschool Symptom Checklist.

problems, a group that staff agree is growing every year. The ESP also serves as a training tool for teachers, helping to fine tune their observational skills, and thus benefitting a larger group of children.

For information on the development of the measure:
Oregon Research Institute
1715 Franklin Blvd.
Eugene, OR 97403-1983
Contact: Edward Feil, Ph.D., Research Associate

A Head Start program currently undergoing training to use the measure:
Western Community Action Head Start
Box 246
Marshall, MN 56258
(507) 537-1416
Contact: Beverly Wilson, Director

Early Preschool Screening materials are available from:
Sopris West
1140 Boston Avenue
Longmont, CO 80501
(800) 547-6747

Using Research to Improve Mental Health in Head Start

Research-based attention to the emotional and behavioral status of the children and families served by Head Start is limited. In fact, the history of research in Head Start, as outlined by Edward Zigler and Sally Styfco in *Head Start and Beyond: A National Plan for Extended Childhood Intervention* (Yale University Press, 1993), was for decades dominated by one variable: IQ. Despite the broader aims of the architects of Head Start, two factors—a scientific interest in the malleability of intelligence and policymakers' interests in IQ gains among children in poverty—conspired to limit the evaluation of the impact of Head Start to changes in the IQ. The societal and scientific focus on intelligence as the only outcome of early childhood programs left a glaring

gap in the knowledge of the effect of Head Start on children's social and emotional development. That gap is only beginning to be addressed by attention to emotional and behavioral competencies. A few measures have been in use informally (for instance, a "Social Attributes Checklist" reproduced in a 1994 special issue of the *National Head Start Bulletin* on mental health (#49, page 17)). However, there has been no systematic validation of this or other competence instruments on a variety of Head Start populations.[63]

In addition, there is also an urgent need for research to document the extent to which emerging early childhood mental health and family support practice strategies achieve intended impacts. This is crucial to help the field make the hard program and resource choices that will maximize the impact of Head Start on the emotional well-being of children and families. At present, there is woefully little evaluation to guide the choice of one mental health related strategy over another, or even to help program directors and management staff envision the potential strategies they might use. Anecdotally, many programs report increased parent involvement, or improved classroom environment as staff competence in meeting the needs of challenging children or helping families address complex issues increases as a result of changes in mental health approaches. Empirically, however, there is little data to guide the field. To that end, this report suggests the kinds of questions that need answers.

- ***How does participating in the general Head Start program affect the mental health of children and families?*** What emotional and behavioral growth and changes do they experience in the course of Head Start and subsequently? How do the changes relate to real outcomes for families in terms of the child's school behavior, or the parents' decreased isolation or greater attachment to the workforce?
- ***How does participating in the general Head Start program affect the mental health of children and families with multiple stressors? with identified emotional and behavioral problems?*** What happens to children who are identified specifically as having serious emotional and behavioral problems—children who have experienced trauma; children whose behavior suggests early onset of problems, particularly conduct disorders? How does participating in community activities affect parental well-being, particularly parents showing high levels of depression? What, if any, are the impacts on fathers? (No programs that we identified focused, as part of a mental health strategy, on fathers.)[64]
- ***What is the relationship between increased staff mental health-related skills, quality of program and outcomes for children?*** This report has emphasized the role of mental health consultants in helping staff learn new strategies to relate to and work with children and families. Yet no research has ever looked at how increased mental health-related skills and improved well-being among staff might affect children and families. Do "one-shot" mental health-related workshops differ from curricula with on-site follow-up support in their effects on staff skills development and satisfaction and child and family mental health outcomes? Does ongoing clinically informed supervision make a difference? Do increases in staff well-being translate

into benefits for children and families in Head Start? Do changes in staffing policy—for instance, lowering the staff-to-family ratio of family advocates—have effects on child and family mental health outcomes. If so, do the effects occur indirectly through increases in intensity of services, quality of services, or staff satisfaction and well-being, or are they effective only in conjunction with increased skill building? In all of these areas, natural variation across sites could be investigated, and linked to outcomes for children, families, and staff.

- ***What difference do various deliberate mental health approaches make either alone or in combination in achieving positive outcomes for children and families, especially those that seem most at risk?*** This report documents that programs are using a range of mental health strategies, combined in many ways. Yet few of the enriched approaches reviewed in this report have been or are being evaluated, for their impacts on children and families or staff. (Those that are tend to be the more structured efforts: the Choosing Non-Violence or the MAP Project, or assessment tools, such as the Early Screening Project or the Pre-School Symptom Checklist.) The need for more formal evaluation to assess the impact on children, families, and staff and overall program quality of these combinations of approaches is critical, and might be structured to take advantage of naturally occurring variation.
- ***What difference does the intensity of a specific service strategy make?*** Research on the long-term outcomes of early childhood programs described in this report suggests that intensive child-focused strategies coupled with intensive family-focused strategies made the difference. Most of the programs that achieved long-term effects on such outcomes as delinquency were even more intensive than Head Start. But our study suggests that some Head Start programs, such as those described in this report, provide mental health and family support services that approach the intensity of the demonstration programs with those long-term effects. Holding the concentration of risk factors in the population constant, how do the short- and long-term outcomes of programs such as those described here compare with programs using more traditional mental health strategies limited to assessment and referrals?
- ***What is the prevalence of serious emotional and behavioral disorder in young children?*** What is the prevalence of combinations of risk and protective factors that put young children at high risk of developing disorders? How does the prevalence of disorders and risk and protective factors vary across different kinds of communities? How is the Head Start program affected by having large numbers of children and families exposed to multiple risk factors? At present, there are no epidemiological data on young children in general, and Head Start children in particular, that identify patterns of normal behavioral and social development. In addition, no prevalence data exist on children at high risk for developing disorders, or the prevalence of atypical behavior, although a special focus on Head Start children is included in a large national epidemiological study currently underway.[65]

Methodologies to answer some of these questions will be, of necessity, complex. Adapting the service systems research approaches that have proven useful in evaluating cross-system mental health and family support-related initiatives for older children and families would be helpful. So, too, would the development of at least a core of measures that researchers could use to assess mental health-related impacts, preferably measures with some face validity to give feedback to staff. What appears to be lacking is an infrastructure to promote and support the research. Clearly there are some things programs can do but there is also a need for a national effort to build a research agenda to address the difficult and important questions raised here.

Financing Mental Health Services in Head Start

Child Development Resources of Ventura County Head Start and Ventura County Mental Health, Oxnard, California

How to fund an enriched mental health strategy is, not surprisingly, the central question posed by Head Start directors and management staff. There are no easy answers. The picture is particularly complicated since we are in the midst of a dramatically changing funding world. Devolution, the shift of responsibility and resource allocation authority from the federal to state and sometimes to local governments, provides both opportunities and constraints, and these will vary state by state. Managed care similarly carries risks and opportunities. However, EPSDT and Medicaid protections and provisions for young children continue. Although historically, links between Head Start and Medicaid have been weak, there are opportunities to use Medicaid and EPSDT, which requires that all eligible children receive early and periodic screening, diagnosis, and treatment, not just for physical, but also for emotional and behavioral problems[56] for mental health services. Below, we describe one Head Start program that undertook a particularly creative funding strategy using Medicaid as the core. We also highlight other fiscal strategies mentioned by programs described in this report.

In Ventura County, California, Head Start and the County Mental Health agency have joined forces to fund mental health services in Head Start through Medicaid; and to systematically screen children in Head Start through EPSDT for emotional and behavioral problems. In the process, they collaboratively pieced together a vision of a responsive, deliberate and comprehensive mental health strategy.

Until recently, the Ventura County Head Start program, which serves 986 children and families in Ventura County, California, did what many Head Start programs do for their mental health services: they relied on private mental health consultants to provide services. As costs increased, the program could no longer support a full-time mental health consultant. One part-time consultant, serving 986 families, could do little more than the required observations in the classroom and fielding of referrals. Moreover, the sense was that when she was really needed, she wasn't available. It was clear that the needs of families, children, and staff required more than this minimal contact.

State-Level Head Start/Medicaid Collaboration: The View from Maine

The Head Start Maine Collaboration Project was one of the first demonstrations initiated to build closer links between Head Start and the states. As part of a broad range of efforts to include Head Start in statewide service integration reforms, staff of the collaboration project spearheaded efforts to better integrate the state's Medicaid program with Head Start and to use the Medicaid Preventive Health Care Program to pay for activities such as outreach, health education, case planning related to mental health, referral and screening, and counseling.[67] Through a process that included convening a state team, designating all Head Start centers as Medicaid-reimbursable Preventive Health Programs and carrying out a time study, the state developed a strategy to implement these changes. The state's Head Start health service money was used as the match for Medicaid services. State Head Start money was thus freed up for other kinds of activities.

Maine Head Start/Medicaid Project
Department of Human Services, State Office of Head Start
State House Station 11
Augusta, ME 04333-0011

Cheryl A. Leeman, *The Maine Experience: Head Start's Participation in the Medicaid EPSDT Program* (January 1994). Report describing the collaboration process, carried out by the Head Start/Maine Collaboration Project, between Head Start and Maine's Medicaid program. The report is available from the office listed above.

For information on other Medicaid Head Start collaboration efforts, contact:
Start Healthy, Stay Healthy
Center on Budget and Policy Priorities
777 North Capitol Street, NE, Suite 705
Washington, DC 20002
(202) 408-1080
Donna Cohen Ross, Project Director

When Ventura County Mental Health reached out to Head Start with an invitation to collaborate, Head Start seized the opportunity. The Ventura County Mental Health agency has long been known in the children's mental health world as one of the pioneers of system-of-care efforts, with a clear track record of providing responsive services and saving dollars.[68] The initial agreement to provide an on-site mental health consultant led to a broader collaboration in which Head Start and Ventura County Mental Health share the costs of one full-time mental health consultant devoted to Head Start. At the core of this strategy is the creative use of Medicaid (in California, known as MediCal). Ventura County Mental Health is reimbursed by MediCal for half of the consultant's salary, while Head Start pays the other half. In this case Head Start dollars for mental health services draw down federal Medicaid dollars through the local mental health agency, at zero net cost to Ventura County Mental Health. The dollars generated through this collaboration covered the extra cost of hiring a bilingual consultant (half of the county's Head Start families are Latino, and many of the parents speak only Spanish).

The full-time consultant travels from Head Start center to center (there are 17 in the county), conducting class observations, and consultations with staff, offering case management, and therapy with families. MediCal dollars

MediCal (California Medicaid) dollars cover her work in the area of treatment as well as in prevention, which includes such activities as classroom consultation for teachers working with children whose behaviors do not meet criteria for diagnosis, but which are nonetheless difficult and challenging.

cover her work in the area of treatment as well as in prevention, which includes such activities as classroom consultation for teachers working with children whose behaviors do not meet criteria for diagnosis, but which are nonetheless difficult and challenging. She is also involved in weekly case conference meetings with the coordinators of the other Head Start components and the program manager, ensuring that family referrals are followed up and do not fall between the cracks.

The consultant has entered into the life of the Head Start culture in ways no previous consultant had. She plays with the children, makes home visits and is generally available. At the same time, during the first 20 months of the partnership, both financial and system glitches have had to be worked out, as the mental health system culture and the Head Start culture come together.

There is also recognition on the part of both Head Start and the mental health agencies that changes now in place are not enough. These include a very low rate of referrals for children with emotional and behavioral disorders (in one recent year, only three-tenths of one percent of children in Child Development Resources of Ventura County Head Start were referred for an emotional or behavioral disorder). In response, Ventura County has begun efforts to better screen children and educate staff to reorganize problems. Through a collaboration with Dr. Michael Murphy, a psychologist from the Massachusetts General Hospital, funded with a grant from the Annie E. Casey Foundation, Ventura Head Start is testing a short checklist for preschoolers with behavioral problems for its use as part of the EPSDT screen. The Preschool Symptom Checklist, in an initial study in Ventura County, was found to be valid for the Head Start children (in other words, it was highly associated with parent ratings on other assessment tools, with the Early Screening Profile, and with actual referral for mental health services). As part of that collaboration, Dr. Murphy has also been meeting with the staff of the Head Start program to provide them with support, training, and consultation. While at present, the mental health-related staff development component is separate from the work of the on-site mental health consultant, the hope is to integrate the child- and family-focused work of the Ventura County mental health consultant and the staff training and development strategy more closely in the future, as well as to find funding for the staff development work.

Ventura County Mental Health also hopes to create interdisciplinary teams, made up of a drug and alcohol treatment specialist, a social worker, and a Head Start family services worker, to intervene with families with substance abuse issues. The county has already implemented these teams in its family preservation services for families with children referred to foster care; the teams are financed through Medicaid in much the same way as the Head Start mental health services are funded. In addition, the county is currently looking at how to ensure continuity in mental health services mandated by MediCal as Head Start children enter public schools all over the county.

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(805) 652-6737
Contacts: Donald Kingdon, Chief, Child and Adolescent Services
Craig Ichinose, Senior Research Psychologist

Other Dollar-Stretching Strategies to Support Enriched Mental Health Approaches

- *Cost share with mental health agencies.* The programs reported here have used a variety of cost-sharing strategies, from mental health agencies assuming the supervisory costs of interns, to cost-sharing for particular services or staff, with or without Medicaid dollars. Negotiating such efforts, in the context of a deliberate strategy to enrich mental health supports to children, staff, and families, is key to building broad support.
- *Use Head Start quality improvement money flexibly.* Some Head Start programs are using program improvement monies to supplement mental health services, spreading funds flexibly across traditionally separate components. For example, at Action for Boston Community Development (ABCD) (profiled in Chapter 3), the director decided to devote a portion of her family service coordinator lines to fund mental health/family services supervisors with clinical experience.
- *Collaborate in community-wide systems integration efforts.* Many communities are now initiating systems integration efforts (see Chapter 4). In several of the programs we contacted, such as the Hawkeye Area Community Action Program Head Start in Cedar Rapids, Iowa, Head Start was involved in community-wide collaborations that led to cost-sharing agreements, which in turn led to improvements in Head Start's ability to access and/or provide a range of mental health and family support services.
- *Reach out to progressive managed care companies.* Inform managed care companies of the needs of the Head Start community and build collaborations. Work with the state Head Start collaborations to ensure that Head Start managed care efforts are in place and that they include attention to the financing of appropriate mental health strategies for Head Start. Provide workshops and information to families and staff about how to choose managed care, including what to look for in mental health benefits.

Developing National Training and Technical Assistance for Head Start Programs and Mental Health Consultants

Creating a national technical assistance strategy to enhance mental health in the context of Head Start has never been a high priority.[69] For the reasons outlined in this report, that include the promulgation of new Performance Standards, growing research knowledge about effective strategies to enhance family and child mental health, and growing concern about the overall quality of many Head Start programs, this may be an opportune time to rethink the national role in enhancing responsive mental health approaches in Head Start. The current reality is that despite increasing enrollments, programs have had to adapt to a changing and downsized training and technical assistance system that provides little attention to mental health-related issues.

Regional offices basically respond to crises and programs most out of compliance. They have little capacity to address mental health issues. Only one regional office we contacted had even a health/disabilities specialist. A related problem is that the regional offices do not, as a routine, compile data on mental health-related needs or shortcomings of programs when analyzing program monitoring forms. This results in a lack of awareness about the most pressing mental health-related needs of programs. Further, when a relevant training or technical assistance need arises, programs have no one with expertise in mental health and family support to turn to at the regional level. A staff position devoted to mental health issues at each regional office would begin to rectify the situation. If that is not possible, at the very least advisory teams should be organized in each region to oversee the mental health-related needs of programs. The teams could be linked to the regional offices as well as the other components of the national support system, and could involve leaders in state mental health departments as well as Head Start staff involved in exemplary programs and state collaborations.

Technical Assistance Support Centers (TASCs) are focused on enhancing the educational components of Head Start, and although they hear many concerns about the emotional and behavioral problems of the children, do not have a mandate to address this in a holistic way. The Resource Access Projects (RAPs) are charged to help programs address the needs of children with disabilities. However, very few of the Head Start children are identified as having emotional and behavioral disabilities (although as noted above, this may not reflect the real situation). This lack of attention to children with this disability has a cost in several ways. First, there is no mechanism for getting state-of-the-art information out to Head Start about new ways to help such children. Thus, as noted earlier, it is not surprising that the Head Start community in general has little information about, or involvement with system-of-care efforts to serve seriously troubled Head Start children and their families. Some Resource Access Projects organize annual conferences for disabilities coordinators.[70] These forums provide valuable opportunities for ongoing training, technical assistance, information sharing, and support. Because mental health is not within the purview of the RAPs, however, they cannot organize similar meetings for mental health coordinators. Defining mental health (including both prevention and treatment) as one of the content areas for which RAPs are responsible would make it possible to include information on mental health-related strategies and issues on the agenda. Since many disability coordinators are also mental health coordinators, the

cost increase would be marginal, although ideally, mental health consultants would also be a part of the process. (At the state level, State Head Start Associations could also organize training and support meetings for mental health coordinators and consultants.)

Recent changes in policy have resulted in providing money directly to programs to fund their own training, rather than supporting the level of national training as had been done in the past. Although this system allows for local control and flexibility, training funds are scarce, whether in mental health or other areas. National training contracts are addressing part of this gap by developing written materials in each component area to serve as guides. This effort, however, does not address the training needs of programs in resource-poor communities, nor does it provide for the kind of interactive, hands-on training and support that is crucial for strengthening mental health approaches, as noted so strongly by the Task Force on Head Start and Mental Health and the National Head Start Association.[71] Further, no one is explicitly charged to help families whose children are at risk of developing more serious emotional and behavioral problems, with supporting staff dealing with these high risk children, or with helping program directors and the Head Start management teams develop strategic planning processes and approaches to infuse a strength-based family oriented mental health perspective in Head Start.

The message from *Lessons from the Field* is clear. Building a system to support creativity and innovations in strengthening mental health in Head Start is likely to have significant payoff, but it will require not only research to test this out, but a significant rethinking of technical assistance and support approaches as part of a national leadership effort.

CHAPTER 6

Building Solutions: Recommendations for Strategies to Improve Mental Health in Head Start

Lessons from the Field has three central messages. First, the goal of the programs highlighted here is to create a holistic vision in which mental health strategies work in the service of staff, families, and children in a coherent manner. This is in contrast to the widely acknowledged reality that many Head Start programs take a very narrow view of mental health, focusing on observations, referrals and diagnoses, and having access to a mental health consultant only on an "on-call" basis. This however, does not really meet the needs of the staff, the families, or the children.

Second, embedding new approaches to mental health in the context of Head Start is difficult. There are no quick fixes or even quick answers to enhancing the capacity of Head Start to better support the emotional and behavioral well-being of families and children living with many risks and stressors. None of the programs described is fully satisfied with where they are; all are in process, and all have faced many bumps and challenges along the way in terms of finding the right people, the right approach, and stable funding.

Third, despite the important work of the programs we learned about over the course of this study, and no doubt many others that we did not identify, well-developed mental health strategies that can enhance the success of Head Start programs are now too limited, too unevaluated, and too unsupported with training and technical assistance.

The recommendations below frame an action agenda to meet the challenges set forth in this report. They grow directly from the programs described in this report who have pioneered responsive approaches to better meeting the real needs of the children and families they see every day. We believe they are particularly important in the light of the emerging effort to implement the new Head Start Performance standards. The recommendations are organized to highlight what can be done by programs, within the communities in which the Head Start programs exist, at the state level, and at the national level.

What Can Be Done at the Head Start Program and Community Level To Strengthen Mental Health in Head Start?

Integrate a Mental Health Perspective into All Parts of the Head Start Program

Operationalizing the long-standing Head Start commitment to integrate a mental health perspective into all aspects of the program has been elusive. The new performance standards represent an important opportunity to correct this. Programs report that starting the process by bringing the mental health consultant on site often has a positive snowball effect. To build the needed vision and strategies, Head Start programs can:

- Move from an "on-call" to an "on-site" role for the consultant
- Expand the consultant's role to include home visits and participation in staff and management meetings and staff-development activities.
- Integrate the mental health/family support perspective into all activities of the program.
- Use planning strategies to help Head Start directors and management teams envision and develop strategic mental health approaches that strengthen the quality of the program and the capacity of each program to respond to the level of stress among Head Start children and families.

Empower and Support Staff while Building their Mental Health Expertise

Empowering staff to help families see and act on their strengths means building staff skills in observing and understanding behavior, and developing intervention strategies. It means helping staff see families and children in new ways, focusing on their strengths. And it means providing staff with educational and career opportunities. But it also means helping them deal with job-related stresses. To that end, Head Start programs can:

- Involve the consultant in regular management and/or cross-component meetings and activities.
- Support the well-being of staff.
- Encourage and facilitate opportunities for staff to explore cultural and ethnic differences, including those regarding discipline, in ways respectful of families and Head Start staff.
- Ensure that training curricula related to mental health competencies are not "one-shot" workshops, but provide ongoing support.
- Develop career ladders for staff interested in mental health/family support.
- Make use of Family Development credentialing programs, if available.

Be Sensitive to the Community and Cultural Meanings of Mental Health

"Mental health" is a forbidding phrase to many Head Start families, as well as to some staff. Traditional mental health consultation and service models applied to Head Start programs serving very diverse populations often meet with resistance or indifference on the part of families and staff. Programs that are successful in providing holistic, family-focused mental health components often have had to revise their ways of approaching mental health. Adapting to the attitudes and cultural traditions of families helps. So too, does using

Where to Find It: A Guide to Mental Health Program and Fiscal Strategies Highlighted in *Lessons from the Field*

To develop an overall approach to mental health, mental health coordinators and program directors or delegate agency directors report:

- Creating an interagency planning committee focused on mental health that includes key leaders from the community, e.g., parents, school superintendent, chair of mental health board, outreach director for health and mental health managed care organizations serving the community (Ulster County, Chapter 3).
- Using the mental health subcommittee of the Health Advisory Committee (Ulster County, Chapter 3).
- Participating in community-wide collaborations to plan for and integrate services for young children and their families through family resource centers, and service integration efforts (Hawkeye Area Head Start, Chapters 3 and 4).
- Carrying out internal assessments with program staff and families (many programs).

To enhance mental health-related competencies in Head Start staff, mental health consultants collaborate with staff by:

- Offering in-classroom coaching and mentoring (Nassau County, Chapter 2).
- Facilitating teacher support groups (Nassau County, Chapter 2).
- Participating in and being a consultant to routine staff meetings (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Facilitating group consultation and support to home visitors and/or family service workers (Rosemount Head Start, Chapter 2).
- Facilitating peer support meetings with family service workers (Head Start Parent Involvement Project, Chapter 3).
- Facilitating classroom or cross-component team meetings (Hawkeye Area Head Start, Chapter 3).
- Providing individual consultation to the director and staff (Nassau County, Chapter 2, and many of the other programs).
- For programs with multiple sites and multiple consultants, convening a network of mental health consultants and providing periodic support meetings (Action for Boston Community Development, Chapter 3).

To help individual children in the classroom, mental health consultants in Head Start are collaborating with staff by:

- Using teacher-friendly, validated screening for children's emotional and behavioral development as a tool to help teachers as well as children (Early Screening Project, Chapter 5; Ventura County, Chapter 5).
- Providing one-on-one in-classroom consultation on specific children, problem-solving with teachers to develop interventions (Nassau County, Chapter 2; St. Bernard's, Chapter 2).
- Helping to implement classroom prevention strategies (Choosing Non-Violence, Chapter 2; Management and Prevention Project, Chapter 2).
- Working with teachers to integrate mental health into classroom curricula, e.g., using stories to discuss such difficult issues as violence and grief (St. Bernard's, Choosing Non-Violence, Chapter 2).
- Using specially trained volunteer students to work with individual children (Jumpstart, Chapter 2).

To enhance strategies to engage and help families, Head Start staff and mental health consultants are:

- Helping staff examine their assumptions about families, enhancing their skills in identifying and building on family and cultural strengths (Nassau County, Chapter 2; Resiliency Partnership-Directed Intervention, sidebar in Chapter 3; Hawkeye Area Head Start, other programs as well).

- Identifying mentor parents, who provide extra support to isolated, hard-to-engage, or stressed parents (Hawkeye Area Head Start, Chapter 3; Resiliency Project, sidebar in Chapter 3; Free to Grow and Community Partnership for Child Development (CPCD) Head Start, Chapter 4).
- Helping families create a resource exchange to share skills (Hawkeye Area Head Start, Chapter 3).
- Using staff and mental health consultants to enhance parenting skills in a family friendly way (Partners Parent Training, sidebar, Chapter 3).
- Using parent support groups to enable parents to discuss issues of most concern to them at their own pace. Remaining on the alert for serious problems (e.g., clinical depression, suicidal behaviors) (Ulster County, Chapter 3; Resiliency Project, sidebar in Chapter 3).
- Helping families with the transition to school, especially when parents own school history has not been positive, e.g. rehearse parent-teacher conferences (St. Bernard's, Chapter 2).
- Opening staff training sessions on mental health-related topics to parents and other caregivers (many of the programs).
- Developing targeted strategies for specific groups of families, e.g., hard-to-engage families or families involved with substance abuse (Head Start Parent Involvement Project, Chapter 3; Resiliency Project, Chapter 3, sidebar; Free to Grow and CPCD Head Start, Chapter 4).
- Providing families of children showing serious behavioral or emotional problems with access to nontraditional mental health services, such as respite care or in-home therapy (Stark County, Chapter 4).

To expand training opportunities related to mental health, Head Start programs are:

- Providing Head Start as a training site for social work and psychology interns (Supervision can be provided either by the Head Start program, if necessary hiring a qualified supervisor with Head Start funds, or by a local mental health center or other approved training site (Ulster County, Chapter 3).
- Providing Family Development Certification courses for Head Start staff (Hawkeye Area Head Start, Chapter 3).
- Building career ladders for staff interested in family support and mental health, working with local community colleges or other training institutions (Action for Boston Community Development (ABCD), Chapter 3).
- Developing courses in conjunction with local community colleges in family support/mental health (ABCD, Chapter 3).

To maximize dollars and resources for mental health-related activities, Head Start programs are:

- Collaborating with mental health centers to maximize the use of Medicaid dollars (Ventura County, Chapter 5).
- Networking with managed health and mental health care providers (St. Bernard's, Chapter 2; ABCD, Chapter 3).
- Developing jointly-funded projects with local community mental health and family support agencies (Nassau County, Chapter 2; St. Bernard's, Chapter 2; Stark County, Chapter 4; Ventura County, Chapter 5).
- Encouraging states to facilitate Head Start/Medicaid collaborations (sidebar on state-level Head Start/Medicaid collaborations in Chapter 5).
- Working with children's mental health advocates to increase mental health dollars targeted for early childhood mental health initiatives (Stark County, Chapter 5).
- Pooling Head Start funds to hire mental health professionals (ABCD, Chapter 2).
- Using volunteer mental health professionals (Rosemount, Chapter 2).
- Using well-supervised psychology and social work interns (Ulster County, Chapter 3).

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Where to Start: Beyond Observations, Diagnoses, Referrals and "On-Call" Consultants

The programs highlighted in *Lessons from the Field* include the following strategies to start the process of making mental health more integrated into the entire program and responsive to the needs of children, families and staff.

- *Find out what the greatest needs of families and staff are. Assess the reactions to the current mental health strategies.* Find out from staff and families what they think is needed. Do it formally (with a survey) or informally. It may be helpful to ask staff or parents to prioritize their needs. Find out how staff and families feel about current mental health efforts. What happens when staff get "stuck"? Carrying out an agency-wide needs assessment can also lead to greater staff and family involvement in developing action plans to address the needs.
- *Convene a meeting of local service administrators, including mental health administrators, to initiate or improve Head Start-agency partnerships. Build a vision for a new mental health strategy.* Include Head Start families, leaders from local family support programs, the schools (one program included the school superintendent in a local planning process), community mental health, managed care entities serving the community, any early childhood planning bodies, county supervisors and others able to play a key facilitating role. Some programs have expanded Head Start Health Advisory Committees to include a stronger focus on mental health as the basis for strategic development.
- *Bring the mental health consultant on-site.* The benefits of having a mental health consultant who is on site often enough and regularly enough to be known and trusted by the staff and families is a "bottom line" requirement. When consultants are at the program regularly and for enough hours to be a consistent presence to staff and families, the result is often a positive snowball effect. Bringing the consultant "on-site" leads to their involvement in parenting workshops and staff training, builds trust between parents, teachers and family service workers, and results in a greater willingness on the part of parents to talk to staff, become more involved with Head Start and get specialized help when necessary.
- *Be willing to experiment and modify services when they seem inadequate.* Successful mental health strategies have in common a willingness of the mental health consultant and the Head Start staff to keep modifying their services until they get it right. The continual revision reaches beyond a traditional and narrow concept of mental health. It may take a few tries to find the solution best tailored to the mental health-related needs of program families. For instance, at one Head Start program serving primarily African American families, the director quickly found out, as have so many other Head Start directors, that expecting families to accept referrals to off-site mental health services was "naive." She and her staff also discovered that families were most open to accepting services when in crisis. Therefore, they decided to work with the local mental health agency to open an office on-site at Head Start. Mental health consultants are thus at the center, receiving dual supervision from their agency and from Head Start, and immediately available to help families in crisis.

terms acceptable to families, such as early interventionists, instead of "off-putting" mental health terms. Using these lessons, Head Start programs can:

- Work with families and use community planning mechanisms to explore cultural issues related to mental health.
- Let families get to know the mental health consultants at a location where the families, children, and staff feel comfortable.

- Include explicit support of cultural traditions in efforts to promote wellness and cope with stress in families.
- Use explicit strategies and language to make mental health "user-friendly."

Tailor Screening Assessments and Service Strategies to Levels of Need

Screening and assessment of emotional and behavioral problems in children, and the use of systematic strength-based assessment with families, is not widespread in Head Start. Head Start programs can:

- Use screening and assessment tools that have been tested and validated on Head Start children.
- Work with mental health consultants and teachers to target intensive services to those children in each classroom who show the most challenging behaviors.
- Adapt mental health strategies to the intensity of needs and strengths present in families served by the program.
- Use a "system-of-care" approach to meeting the needs of the most troubled children and families, including flexible support services such as one-on-one coaches and respite care.

Develop Community Connections to Enhance Strategic Mental Health Initiatives

Community collaborations can be as simple as a decision to have a mental health worker from a local mental health center come on-site to supervise home visitors, or as complex as agreements hammered out over several years, involving blended funds and staff. All successful collaborations, however, share a commitment to use resources creatively and to engage Head Start management leadership in the process. Building on this, Head Start programs can:

- Take advantage of windows of opportunity to start or improve collaborations with mental health, family support, and substance abuse programs as well as community-based organizations working to address community problems.
- Forge partnerships with mental health training programs.
- Take advantage of Medicaid services and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Join in community planning efforts to create early childhood systems of care and/or comprehensive family support centers.
- Work with managed care providers to develop early intervention and outreach strategies for Head Start.
- Explore ways to help the most stressed Head Start families meet welfare-to-work requirements, building on effective mental health and family support strategies.

What Can Be Done at the State and National Levels to Strengthen Mental Health Approaches in Head Start?

Include Mental Health in the Regional Offices and the Training and Technical Assistance Support System

Despite increasing enrollments, during the past several years, programs have had to adapt to a changing (and downsized) training and technical assistance system that provides little formal attention to mental health-related issues either through the regional offices, the Technical Assistance Support Centers (TASCs) or the Resource Access Projects (RAPs). The national Head Start program can:

- Use the regional and national training and technical assistance system to help Head Start programs choose and use mental health consultants more effectively, build staff mental health competencies, strengthen the intensity of family service work and use the newly promulgated Performance Standards as an opportunity to help programs plan for more responsive mental health strategies.
- Establish a staff position (or, at minimum, an advisory team) with expertise in mental health in every region to help programs and/or grantee agencies develop mental health strategies responsive to the needs of staff and families.
- Develop a system to track mental health approaches and strategies, as well as amount of service provided.
- Organize meetings of mental health consultants and coordinators in each region to share information about effective strategies.

Develop Statewide Collaborations for Mental Health in Head Start

As states assume greater responsibility for decisions affecting young children and families in conjunction with the recent enactment of Temporary Assistance to Needy Families (TANF), as well as Medicaid changes, there will be new opportunities to build stronger collaborative relationships at the state level between Head Start and related programs. States should use this opportunity not just to ensure that children of working parents have access to Head Start and child care, but also to ensure that children and families get the mental health and other supports they need. Both national and state leaders can:

- Continue and expand the Head Start/State Collaboration Projects, and ensure that mental health issues are addressed by them.
- Develop Medicaid/Head Start and Part H/Head Start collaborations sensitive to the particular characteristics of these programs in each state.
- Encourage statewide meetings of Head Start mental health and family support/service staff with mental health consultants.

Provide National Leadership

Some improvements in Head Start's mental health capacity require national leadership to develop and sustain. These improvements include staff development, collaboration with national mental health professional organizations, variation in and enrichment of the Head Start model to

strengthen its preventive potential, and research to inform the Head Start of the 21st century. National leadership from the Head Start Bureau and other organizations will be necessary to:

- Gather routine information on mental health approaches used by Head Start programs.
- Create a nationwide model career ladder for Head Start staff interested in social services, family support, and mental health, and develop systematic internship strategies.
- Expand the pool of culturally responsive mental health professionals in Head Start by developing well-structured volunteer initiatives in conjunction with mental health professional organizations.
- Provide ongoing support to programs to implement deliberate, holistic mental health strategies to meet the objectives of the proposed Performance Standards.
- Build links with ongoing national efforts, such as Start Healthy, Stay Healthy, mounted by the Center on Budget Policy and Priorities, to ensure that eligible children in child care settings, including Head Start, are enrolled in Medicaid and thus are able to access mental health as well as physical health services.
- Test strategies to apply research-based knowledge to strengthen the capacity within Head Start to prevent emotional and behavioral problems in children.

Support Research Related to Mental Health in Head Start

Historically, there has been little research attention to the mental health of children and families, the well-being of Head Start staff, or the relationship between program quality and the level of mental health support for staff, children and families. Nor has there been attention to service delivery strategies. Enhancing the knowledge base about these issues in the next generation of Head Start research can help inform program and policy in a time of scarce resources and high need.

- Incorporate measures on behavioral and emotional outcomes, as well as risk and protective factors, in all research carried out on Head Start populations.
- Explore how the Head Start experience in general affects emotional and behavioral patterns in children.
- Explore the effects of different combinations of mental health strategies in Head Start on all children, on children at risk of developing conduct disorder and other emotional and behavioral problems, on children with identified emotional and behavioral disorders, and on families with different levels of stress.
- Conduct studies to determine the prevalence of serious emotional and behavioral disorders in young children served by Head Start, the prevalence of combinations of risk and protective factors that affect the development of such disorders, and variation in these disorders and factors across different kinds of communities.
- Examine the impact of managed mental health care on the delivery system for mental health in Head Start.

The message from the field is clear. The need to pay greater attention to mental health-related issues in Head Start is urgent; the strategies are emerging; and the opportunities to build a more coherent response over the coming years are too important to be ignored. *Lessons from the Field* suggests concrete, cost-responsive directions forged program by program through trial and error. Implementing these new directions more broadly will require public leadership by government at the federal, state, and community levels, as well as public-private partnerships. It will involve some new resources and redirection of existing resources. It will also require capitalizing on the positive aspects of devolution—greater flexibility at the state and community levels—and of managed care. But the task is achievable, the need compelling, and the vision becoming clearer.

ENDNOTES

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3. See, for example, Knitzer, J. (1996). Meeting the mental health needs of young children and their families. In B. A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society.* Baltimore, MD: Paul H. Brookes, pp. 553–572.

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4. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families. (April 22, 1996). Notice of proposed rule making—Head Start Performance Standards. *Federal Register,* 61(78), pp. 17754–17792.

5. See Knitzer, J. & Page, S. (1996). *Map and track. State initiatives for young children and families.* New York, NY: National Center for Children in Poverty, Columbia School of Public Health. This recent National Center for Children in Poverty report found that at least 20 states had either state- or state- and community-level planning cross-program strategies involving young children and families.

6. See Institute of Medicine, National Research Council, Commission on Behavioral and Social Sciences and Education, Board on Children, Youth, and Families, Roundtable on Head Start Research; Phillips, D. A. & Cabrera, Natasha J. (Eds.) (1996). *Beyond the blueprint: Directions for research on Head Start's families.* Washington, DC: National Academy Press.

7. See reference 2.

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18. Olds, D. L. & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. *The Future of Children,* 3(3), pp. 53–92.

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See Lally, J. R.; Mangione, P. L.; & Honig, A. S. (1988). The Syracuse University Family Development Research Program: Long-range impact of an early intervention with low-income children and their families. In D. R. Powell (Ed.), *Parent education as early childhood intervention: Emerging directions in theory, research and practice* (Annual Advances in Applied Developmental Psychology Vol. 3). Norwood, NJ: Ablex, pp. 79–104, for information on the Syracuse project.

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20. Wasik, B. H. (1993). Staffing issues for home visiting programs. *The Future of Children*, 3(3), pp. 140–157.

21. See reference 13.

22. For a review of supervising and mentoring strategies in infant/toddler programs, see Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and families: A sourcebook*. Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families.

23. The American Association for Marriage and Family Therapy's Training Partnership Project was a pilot program in 9 sites to place interns in training at Head Start centers, and to provide them with the necessary orientation, training, and ongoing supervision at no cost to Head Start. The work the volunteers did was carefully supported by an experienced family therapist, and counted toward an accreditation program. The supervision provided to the Rosemount Head Start Center described in Chapter II was, in part, the model for the volunteer initiative which preceded the Training Partnership Project. (For more information, contact Gwen Freeman, Head Start Project Director, American Association for Marriage and Family Therapy Head Start Training Partnership Project, 1133 15th Street, NW, Washington, DC 20005-2710; (202) 467-5125).

24. See Campbell, S. B. (1990). *Behavior problems in preschool children: Clinical and developmental issues*. New York, NY: Guilford Press.

Data from a longitudinal study of children in New Zealand is also informative regarding long-term consequences of attention deficit and associated behavior problems; see McGee, R.; Silva, P. A.; & Williams, S. M. (1984). Perinatal, neurological, environmental, and developmental characteristics of seven-year-old children with stable behavior problems. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 25(4), pp. 573–586.

25. Kaminski, R.; Stoner, G.; Schaughency, E.; & Bricker, D. (1993). *Serving young children with ADHD and related behavior problems: A management and prevention program*. Grant proposal submitted to the U.S. Department of Education by the University of Oregon, College of Education, School Psychology Program, Eugene, Oregon.

26. See Scholten, E. (1995). Practice perspectives of the Head Start mental health consultant. Holland, MI: Grand Valley State College. Unpublished manuscript.

27. Rainbow House Institute for Choosing Non-Violence. (1994). Children's views. *Institute Insights*, 1(1), p. 3.

28. See Garbarino, J.; Dubrow, N.; Kostelny, K.; & Pardo, C. (1992). *Children in danger: Coping with the consequences of community violence*. San Francisco, CA: Jossey-Bass.

29. Loeber, R. & Dishion, T. (1983). Early predictors of male delinquency: A review. *Psychological Bulletin*, 94(1), pp. 68–99.

30. Holden, G.W. & Ritchie, K. L. (1991). Linking extreme marital discord, child rearing, and child behavior problems: Evidence from battered women. *Child Development*, 62(2), pp. 311–327.

31. See Parry, A.; Walker, M.; & Heim, C. (1990). *Choosing non-violence: The Rainbow House handbook to a violence-free future for young children*. Chicago, IL: Rainbow House/Arco Iris.

32. Barnett, W. S. (1995). Long-term effects of early childhood programs on cognitive and school outcomes. In Gomby, D. S. & Larner, M. B., (Eds.), Special issue: Long-term outcomes of early childhood programs. *The Future of Children*, 5(3), pp. 25–50.

See also Schweinhart in reference 19.

33. Molnar, J. M.; Rath, W. R.; & Klein, T. P. (1990). Constantly compromised: The impact of homelessness on children. *Journal of Social Issues*, 46(4), pp. 109–124

Wood, D. L.; Valdez, R. B.; Hayashi, T.; & Shen, A. (1990). Health of homeless children and housed, poor children. *Pediatrics*, 86(6), pp. 858–866.

34. For more information on the development of the model of mental health for St. Bernard's Head Start, see Donahue, P. J. (In press). The treatment of homeless children and families: Integrating mental health services into a Head Start model. In A. Zelman (Ed.), *Intervention for children at high risk : Preventive psychiatry in action*. Northvale, NJ: Jason Aronson. This chapter provides more detail, including vignettes, about the challenges and successes experienced by the St. Bernard's collaborators.

35. Parker, F. L.; Piotrkowski, C. S.; Horn, W. F.; & Greene, S. M. (1995). The challenge for Head Start: Realizing its vision as a two-generation program. In S. Smith (Ed.), *Two generation programs for families in poverty: A new intervention strategy*. Norwood, NJ: Ablex, pp. 135–160.

36. Washington, V. (1985). Head Start: How appropriate for minority families in the 1980s? *American Journal of Orthopsychiatry*, 55(4), pp. 577–590.

Stevenson, H. C. & Abdul-Kabir, S. (In press). Reflections of hope from the "bottom:" Cultural strengths and coping among low-income African-American mothers. In *Proceedings of the Roundtable on Cross-Cultural Psychotherapy, 1995*. New York, NY: Teachers College, Columbia University.

37. See Belle, D. (Ed.). (1982). *Lives in stress: Women and depression*. Newbury Park, CA: Sage.

38. Downey, G. & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108(1), pp. 50–76.

39. Parker, F.L.; Piotrkowski, C.S.; Clark, B.; Peay, L.; Young, S.; Flynn, C.; & Baker, A. (1996). *Head Start Parent Involvement Project. Final report to the Administration on Children, Youth and Families. Part III: Strategies to enhance staff's work with parents: A process of self-awareness, learning, and peer support*. New York, NY: National Council of Jewish Women, Center for the Child.

40. Parker, F. L.; Piotrkowski, C. S.; & Peay, L. (1987). Head Start as a social support for mothers: The psychological benefits of involvement. *American Journal of Orthopsychiatry*, 57(2), pp. 220–233.

41. Miller, J. B. (1986). *Toward a new psychology of women, 2nd ed.* Boston, MA: Beacon Press.

42. Fantuzzo, J.; Coolahan, K.; & Weiss, A. (In press). Resiliency partnership-directed intervention: Enhancing the social competencies of preschool victims of physical abuse by developing peer resources and community strengths. In D. Cicchetti & S. L. Toth (Eds.), *The effects of trauma on the developmental process.* (Rochester Symposium on Developmental Psychopathology, Volumes 8 and 9). Rochester, NY: University of Rochester Press.

43. See Stevenson & Abdul-Kabir in reference 36.

44. Peters, D. L. & Deiner, P. L. (1987). The reality of early childhood: Head Start and the Child Development Associate (CDA). *Topics in Early Childhood Special Education*, 7(3), pp. 48–58.

45. The Cornell Family Development Program is also developing a credentialling program. Contact Betsy Crane, Cornell University Empowering Families Project, Department of Human Development and Family Studies, G-37 MVR Hall, Ithaca, NY 14853–4401; (607) 255–2531.

46. Cole, R. F. & Poe S. L. (1993). *Partnerships for care: Systems of care for children with serious emotional disturbances and their families. interim report of the Mental Health Services Program for Youth.* Washington DC: Washington Business Group on Health.

Jordan, D. D. & Hernandez, M. (1990). The Ventura planning model: A proposal for mental health reform. *The Journal of Mental Health Administration*, 17(1), pp. 26–47.

Kahn, A. J. & Kamerman, S. B. (1992). *Integrating services integration: An overview of initiatives, issues, and possibilities.* New York, NY: National Center for Children in Poverty, Columbia University School of Public Health

47. For an up-to-date report on state-level initiatives in linking services for children and families, see reference 5.

See also Knitzer in reference 3 and reference 11.

48. For examples of this form of community-wide prevention, see Hawkins, J. D.; Catalano, R. F., Jr.; & Associates. (1992). *Communities that care: Action for drug abuse prevention.* San Francisco, CA: Jossey-Bass. This book is a helpful manual on building a comprehensive substance abuse prevention effort based on community organizing and tailoring of proven strategies to the community.

DiClemente, R. J. & Peterson, J. L. (Eds.). (1994). *Preventing AIDS: Theories and methods of behavioral interventions* (AIDS Prevention and Mental Health Series). New York, NY: Plenum Press.

Farquhar, J. W.; Fortmann, S. P.; Flora, J. A.; Taylor, C. B. Haskell, W. L.; Williams, P. T.; Maccoby, N.; & Wood, P. D. (1990). Effects of communitywide education on cardiovascular disease risk factors: The Stanford Five-City Project. *Journal of the American Medical Association*, 264(3), pp. 359–365.

49. See Knitzer in reference 3.

50. Zigler, E. & Muenchow, S. (1992). *Head Start: The inside story of America's most successful educational experiment.* New York, NY: BasicBooks.

51. Aber, J. L. (1994). Poverty, violence, and child development: Untangling family and community level effects. In C. A. Nelson (Ed.), *Threats to optimal development: Integrating biological, psychological, and social risk factors* (Minnesota Symposium On Child Psychology Vol. 27). Hillsdale, NJ: Lawrence Erlbaum, pp. 229–272.

Brooks-Gunn, J.; Duncan, G.; Klebanov, P. K.; & Sealand, N. (1993). Do neighborhoods influence child and adolescent behavior? *American Journal of Sociology*, 99(2), pp. 353–395.

52. For an overview see *Free to Grow: Head Start Partnerships to Promote Substance-free Communities.* (1996). New York, NY: Columbia School of Public Health. This report describes each of the sites briefly.

53. Love, J. M. & Perez-Johnson, I. L. (1995). *Design for a process evaluation of Free to Grow: Head Start Partnerships to Promote Substance-Free Communities.* Princeton, NJ: Mathematica Policy Research.

54. Leaders in the field of drug abuse prevention increasingly advocate such multi-level, comprehensive efforts, and community-wide forums to plan them. For example, one apparently successful substance abuse prevention program, the Midwestern Prevention Project, includes classroom drug education, parent involvement, training on effective parent-child communication, use of community leaders to initiate drug abuse prevention activities, and media coverage.

55. O'Brien, J. (February 1996). Personal communication. U.S. Department of Health and Human Services, Head Start Bureau, Washington, DC.

56. See Sinclair, et al. in reference 10.

See also Fotness & Finn in reference 10.

57. Offord, D. R., Alder, R. J., & Boyle, M. H. (1986). Prevalence and sociodemographic correlates of conduct disorders. *American Journal of Social Psychiatry*, 6(4), pp. 272–278.

58. Campbell, S. B. & Ewing, L. J. (1990). Follow-up of hard-to-manage preschoolers: Adjustment at age 9 and predictors of continuing symptoms. *Journal of Child Psychology and Psychiatry*, 31(6), pp. 871–889.

59. Feil, E. G. & Becker, W. C. (1993). Investigation of a multiple-gated screening system for preschool behavior problems. In Special Issue: Behavior disorders in young children. *Behavioral Disorders*, 19(1), pp. 44–53.

60. Feil, E. (February 1995). Personal communication. University of Oregon, College of Education, School Psychology Program, Eugene, Oregon.

61. Kite, L. A. (February 3, 1995). Personal communication. Coordinator, Head Start and other preschool programs, Texas Region 10 Educational Services Center, Richardson, Texas.

62. LaFreniere, P. J.; Dumas, J. E.; Capuano, F.; & Dubeau, D. (1993). Development and validation of the Preschool Socioaffective Profile. *Annual Progress in Child Psychiatry and Child Development*, pp. 104–122. Reprinted from *Psychological Assessment*, 1992, 4(4), pp. 442–456. Our review of the preschool mental health assessment literature is not comprehensive. We have doubtless omitted other valuable measures.

63. Interest in such measures is high, however; see Garcia-Coll, C. (In press). *The measurement of developmental competencies: Implications for Head Start research.* [Proceedings of a symposium presented at the National Head Start Research Conference, June, 1996, Washington, DC]. Washington, DC: U. S. Department of Health and Human Services, Administration for Children, Youth, and Families.

64. See for example, Levine, J. A.; Murphy, D. T.; & Wilson, S. (1994). *Getting men involved: Strategies for early childhood programs.* New York, NY: Scholastic, Inc.

65. See Head Start sub-study in reference 8.

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66. A demonstration project to foster collaboration between Head Start and the Medicaid EPSDT program was in fact carried out. It resulted in implementation at all programs and dissemination of a handbook on how Head Start programs could make use of the federal program. Over two decades have passed, however, since this initiative. See Zigler & Muenchow in reference 50, p. 155.

For a review of issues relating to Head Start and Medicaid, see Pizzo, P. D. & Chavkin, D. (1991). Head Start and Medicaid: A new marriage for the 1990s. *National Head Start Association Journal*, 10(Spring), pp. 53–57.

67. For further details of the collaboration process, see Leeman, C. A. (1994). *The Maine experience: Head Start's participation in the Medicaid EPSDT program*. Augusta, ME: Maine Department of Human Services, State Office of Head Start.

68. See Jordan & Hernandez in reference 46.

Hernandez, M. & Goldman, S. K (1996). A local approach to system development. In B. A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brooke, pp. 177–196.

69. See reference 2.

70. For example, the Region II Resource Access Project holds an annual Disabilities Coordinators Conference in New York City.

71. See reference 1, pp. 16–17.

National Head Start Association. (1994). The design of a training and technical assistance system for the 21st century. *National Head Start Association Journal*, 13(Summer), pp. 9–13.

APPENDIX A List of Resources

Note: The items described below are a representative selection of the many materials available on this topic. Readers should also contact the organizations, agenices, and publishers listed in Appendix B for information about other publications and audiovisual materials.

American Association for Marriage and Family Therapy (AAMFT) Research and Education Foundation. *A Head Start guide to volunteer services by marriage and family therapists*, and *An MFT guide to Head Start.*

Brief guides, addressed to Head Start staff and AAMFT volunteers, respectively, on volunteer marriage and family therapists in Head Start. AAMFT Research and Education Foundation, 1133 15th Street, NW, Suite 300, Washington, DC 20005; (202) 452-0109/Fax (202) 223-2329/E-mail: www.aamft.org

American Orthopsychiatric Association. *Strengthening mental health in Head Start: Pathways to quality improvement.*

An overview of current mental health needs in Head Start, and strategies to address them. The first report of the Task Force on Head Start and Mental Health. (1994). American Orthopsychiatric Association, 330 Seventh Avenue, 18th Floor, New York, NY 10001; (212) 564-5930/Fax (212) 564-6180/E-mail: amerortho@aol.com

James Bowman Associates. *Caring relationships—resilient communities: Promoting mental health, a training guide for the Head Start learning community.*

A training guide with many case vignettes and activities to promote mental health in Head Start. (1996). U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Head Start Bureau, P. O. Box 1182, Washington, DC; (202) 205-8560/Fax (703) 683-5769

Carter, Sylvia; Oyemade, Ura Jean. *Parents getting a Head Start against drugs. Children getting a Head Start against drugs.*

Workshop manuals for Head Start substance abuse curricula with separate activity books and trainer's guide. (1993; free). National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345; (800) 729-6686/Fax (301) 468-6433; or U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Head Start Bureau, P.O. Box 1182, Washington, DC 20013; (202) 205-8560/Fax (703) 683-5769

Collins, Raymond; Anderson, Penny. *Head Start substance abuse guide: A resource handbook for Head Start grantees and other collaborating community programs.*

A basic resource guide created for the Head Start and early childhood community. (1991; free). U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Head Start Bureau, P.O. Box 1182, Washington, DC 20013; (202) 205-8560/Fax (703) 683-5769.

Donahue, Paul J. *The treatment of homeless children and families: Integrating mental health services into a Head Start model.*

Description of a mental health services model for homeless Head Start families, with many family vignettes. This book chapter describes the challenges and successes experienced by the collaborators at St. Bernard's Head Start (profiled in Chapter III of this Report.) (In press). In A. Zelman, (Ed.), *Preventive psychiatry in action: Interventions with high-risk children.* Jason Aronson Publishers, Northvale, NJ; 800-782-0015/Fax (201) 767-4330

The Early Screening Project. *Systematic screening for behavioral disorders materials.*

This project has developed a validated and easy-to-use strategy for assessing existing emotional and behavioral problems among preschool children. It disseminates information, manuals, a training video, and screening materials. Sopris West, 1140 Boston Avenue, Longmont, CO 80501; (800) 547-6747/Fax (303) 776-5934

Eggbeer, Linda; Fenichel, Emily, Editors. *Educating and supporting the infant/family work force: Models, methods and materials.*

The articles in this special issue of the journal *Zero to Three* describe models for staff training and support in infant/toddler programs. The issue includes an annotated list of curricula and videos addressing this topic. (*Zero to Three*, Volume 15, Number 3, December 1994/January 1995). Zero to Three: National Center for Infants, Toddlers, and Families, 734 15th Street, NW, 10th Floor, Washington, DC 20005; (800) 899-4301 or (202) 638-0840/Fax (202) 638-0851

Fenichel, Emily, Editor. *Learning through supervision and mentorship to support the development of infants toddlers and families: A sourcebook.*

A review of supervising and mentoring strategies in infant/toddler programs. (1992). Zero to Three: National Center for Infants, Toddlers, and Families, 734 15th Street, NW, 10th Floor, Washington, DC 20005; (800) 899-4301 or (202) 638-0840/Fax (202) 638-0851.

Gomby, Deanna S.; Larson, Carole S., Editors. *Home visiting.*

Some of the relevant articles from this special issue of *The Future of Children* are Olds, D. L. & Kitzman, H., Review of research on home visiting for pregnant women and parents of young children, pp. 53–92; Ramey, C. T. & Ramey, S. L., Home visiting programs and the health and development of young children, pp. 129–39; Wasik, B. H., Staffing issues for home visiting programs, pp. 140–157; Halpern, R., The societal context of home visiting and related services for families in poverty, pp. 158–171, and Slaughter-Defoe, D. T., Home visiting with families in poverty: Introducing the concept of culture, pp. 172–183. (*The Future of Children*, Volume 3, Number 3, Winter 1993; free). The Center for the Future of

Children, David and Lucile Packard Foundation, 300 Second Street, Suite 102, Los Altos, CA 94022; (415) 948-3696/Fax (415) 948-6498; WWW: http://www.futureofchildren.org

Gomby, Deanna S.; Larner, Mary B., Editors. *Long-term effects of early childhood programs.*

Some of the relevant articles from this special issue are Barnett, W. S., Long-term effects of early childhood programs on cognitive and school outcomes, pp. 25–50; Yoshikawa, H., Long-term effects of early childhood programs on social outcomes and delinquency, pp. 51–75; St. Pierre, R. G. ; Layzer, J. I.; & Barnes, H.V., Two-generation programs: Design, cost, and short-term effectiveness, pp. 76–93; and Frede, E. C., The role of program quality in producing early childhood program benefits, pp. 115–132. (*The Future of Children*, Volume 5, Number 3, Winter 1995; free). The Center for the Future of Children, David and Lucile Packard Foundation, 300 Second Street, Suite 102, Los Altos, CA 94022; (415) 948-3696/Fax (415) 948-6498; WWW: http://www.futureofchildren.org

Hansen, Kirsten A.; Martner, Janet S. *Mental health in Head Start: A wellness approach.*

A guide for mental health coordinators, consultants and Head Start Staff. Manual and videotapes, in both English and Spanish. (1990). Georg-town University Child Development Center, Head Start Mental Health Project, 3307 M Street, NW; Suite 401, Washington, DC 20007-3935; (202) 687-8635/Fax (202) 687-8899/E-mail: GUCDC@medlib.georgetown.edu.

Hawkins, J. David; Catalano, Richard F. Jr.; & Associates. *Communities that care: Action for drug abuse prevention.*

A guide for initiating community-based drug prevention efforts, informed by the latest research on what the most potent risks for drug abuse are and how to reduce their impact to prevent drug abuse. Two chapters discuss approaches to drug abuse prevention in early childhood. (1992). Jossey-Bass Publishers, 350 Sansome Street, San Francisco, CA 94104; (415) 433-1767/Fax (800) 605-2665 or (415) 433-0499

Head Start Bureau. *Responding to children under stress: A skill-based training guide for classroom teams.*

A guide to addressing the needs of children under stress in Head Start, with training sessions focused on characteristics of children living under stress, suggestions for the classroom environment and scheduling of activities, helping children cope with stress, supporting parents, and problem solving. (1992). U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Head Start Bureau, P.O. Box 1182, Washington, DC 20013; (202) 205-8560/Fax (703) 683-5769

Howell-Lee, Eileen; McGlynn, Jayne E. *Including the child who is highly disruptive.*

Short manual on behavior problems and how to address them.(1992; free). Region II Resource Access Project (RAP), New York University, Pless Building, 82 Washington Square East, Room 665, New York, NY 10003; (212) 998-5528/Fax (212) 995-4562

Knitzer, Jane. *Children's mental health policy: Challenging the future.*

Discusses changes in children's mental health policy. (*Journal of Emotional and Behavioral Disorders*, Volume 1, Number 1, pp. 8–16, 1993).

Knitzer, Jane. *Meeting the mental health needs of young children and their families.*

Discusses how to meet children's mental health needs through informed policy. (1996). In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society.* Paul H. Brookes Publishing Co, P.O. Box 10624, Baltimore, MD 21285-0624; (800) 638-3775 or (410) 337-9580/Fax (410) 337-8539.

Koyanagi, Chris; Brodie, Julie R. *Making Medicaid work to fund intensive community services for children with serious emotional disturbance: An advocacy guide to financing key components of a comprehensive system of care.*

A useful resource for creating a network of mental health and social services using Medicaid funding. (1994). Bazelon Center for Mental Health Law, 1101 15th Street, NW, Suite 1212, Washington, DC 20005; (202) 467-5730/Fax (202) 223-0409

Leeman, Cheryl A. *The Maine experience: Head Start's participation in the Medicaid EPSDT program.*

Report describing the collaboration process, carried out by the Head Start/Maine Collaboration Project, between Head Start and Maine's Medicaid program. (1994). Maine Human Services Department, State Office of Head Start, 11 State House Station, Augusta, ME 04333; (207) 287-5060/Fax (207) 287-5282/E-mail: stetson.dianne@state.me

Litt, Barry. *Head Start and MFT: Tools for empowerment.*

An excellent description of one family therapist's work in developing collaborative partnerships with Head Start staff and families. (*Therapy News*, October, pp. 27–30, 1993). American Association for Marriage and Family Therapy, 1133 15th Street, NW, Suite 300 Washington, DC 20005; (202) 452-0109/Fax (202) 223-2329/E-mail: www.aamft.org

Meier, John H. *Behavior management manual for preschool children, their parents and teachers, revised edition.*

How-to manual on difficult behaviors and how to address them in the classroom and at home. (1994). John Meier, Preschool Services Department, 250 South Lena Road, San Bernardino, CA 92408; (909) 387-2375/Fax (909) 387-3313

Mengel, Patricia N. *Mental health in migrant Head Start.*

Videotapes in both English and Spanish, training manual, and workshop outline. (1991). East Coast Migrant Head Start Project, 4200 Wilson Boulevard, Suite 740, Arlington, VA 22203; (703) 243-7522, extension 244/Fax (703) 243-1259

National Head Start Association. *The design of a Head Start training and technical assistance system for the 21st century.*

A position paper on recommended changes in Head Start's training and technical assistance system, including attention to how the Regional Offices could be strengthened. (NHSA Position Paper, *National Head Start Association Journal*, Summer, Volume 13, Number 1, pp. 9–13, 1994). National Head Start Association, 1651 Prince Street, Alexandria, VA 22314; (703) 739-0875/Fax (703) 739-0878

O'Brien, James. *Head Start and mental health.*

See this entire journal issue, which is devoted to the topic of mental health in Head Start. (*National Head Start Bulletin* , No. 49, 1994). National Head Start Association, 1651 Prince Street, Alexandria, VA 22314; (703) 739-0875/Fax (703) 739-0878

Oshinsky, Carole. J.; Goodman, Barbara; with Woods, Tryon & Rosensweig, Marjorie A. *Building bright futures: An annotated bibliography on substance abuse prevention for families with young children.*

Includes a representative selection of materials that relate to Head Start programs involved in the Free to Grow initiative, which works to strengthen families and help communities organize to prevent substance abuse; materials are also relevant to the needs and concerns of low-income families with young children. (1996). Free to Grow, Columbia School of Public Health and National Center for Children in Poverty, c/o NCCP Publications, 154 Haven Avenue, New York, NY 10032; (212) 304-7100/Fax (212) 544-4200/E-mail: ejs22@columbia.edu

Osofsky, Joy D.; Fenichel, Emily, Editors. *Caring for infants and toddlers in violent environments: Hurt, healing and hope.*

This special journal issue covers exposure of infants and toddlers to violence, and ways programs have addressed the problem. (*Zero to Three*, December/January, Volume 14, Number 3, pp. 1–48, 1994). Zero to Three/National Center for Infants, Toddlers, and Families, 734 15th Street, NW, Washington, DC 20005. (800) 899-4301 or (202) 638-0840/Fax (202) 638-0851

Osofsky, Joy D.; Fenichel, Emily, Editors. *Islands of safety: Assessing and treating young victims of violence.*

This special journal issue is devoted to assessment and treatment of very young children and their families who have been exposed to community or domestic violence. (*Zero to Three*, April/May, Volume 16, Number 5, pp. 5–44, 1996). Zero to Three/National Center for Infants, Toddlers, and Families, 734 15th Street, NW, Washington, DC 20005. (800) 899-4301 or (202) 638-0840/Fax (202) 638-0851

Parry, Anne; Walker, Melissa; Heim, Chris. *Choosing non-violence: The Rainbow House handbook to a violence-free future.*

Manual for early childhood classrooms on dealing with violence within and outside the classroom. (1990). Rainbow House/Arco Iris, Attention: Anne Parry, P.O. Box 29019, Chicago, IL 60629; (773) 521-5501/Fax (773) 521-4866

Piotrkowski, Chaya S; Collins, Ray; Knitzer, Jane; Robinson, Ruth. *Strengthening mental health services in Head Start: A challenge for the 1990s.*

A good overview of the recent history of mental health in Head Start, including discussion of changing needs and how to meet them. (*American Psychologist*, Volume 49, Number 2, pp. 133–139, (1994). American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242; (202) 336-5600/Fax (202) 336-5568

Rainbow House Institute for Choosing Non-Violence; City of Chicago, Department of Human Services and Children's Services Division. *Caring for children in dangerous times: A protocol for responding to violence.*

An excellent protocol, with action plans for Head Start and other early childhood programs to address violence when it occurs both outside or inside the center. (1995). Rainbow House/Arco Iris, Attention: Anne Parry, P.O. Box 29019, Chicago, IL 60629; (773) 521-5501/Fax (773) 521-4866

APPENDIX B

National Organizations Concerned with the Mental Health of Young Children

The Children's Defense Fund (CDF)
25 E Street, NW
Washington, DC 20001
(202) 628-8787
Publications: (202) 662-3652
Fax: (202) 662-3510

Family Resource Coalition (FRC)
200 South Michigan Avenue, 16th Floor
Chicago, IL 60604
(312) 341-0900
Fax: (312) 341-9361

Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7710
Fax: (703) 836-1040

Georgetown University Child Development Center
3307 M Street, NW, Suite 401
Washington, DC 20007-3935
(202) 687-8837
Fax: (202) 687-8899

LINKS
The Judge David L. Bazelon Center for Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005
(202) 467-5730
Fax: (202) 223-0409

National Association for the Education of Young Children (NAEYC)
1509 16th Street, NW
Washington, DC 20036-1426
(800) 424-2460
(202) 232-8777
Publications: (202) 328-2604
Fax: (202) 328-1846

National Center for Children in Poverty (NCCP)
Columbia School of Public Health
154 Haven Avenue
New York, NY 10032
(212) 304-7100
Publications: (212) 304-7119
Fax: (212) 544-4200

National Head Start Association
1651 Prince Street
Alexandria, VA 22314
(703) 739-0875
NHSA Hotline: (703) 739-0879
Publications: (703) 739-0875
Fax: (703) 739-0878

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7722
Mental Health Information Center (800) 969-NMHA
Fax: (703) 684-5968

Start Healthy, Stay Healthy
Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
(202) 408-1080
Fax: (202) 408-1056

State Mental Health Representatives for Children and Youth
Contact your state Mental Health Department or the
National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 739-9333
Fax: (703) 548-9517

Zero-to-Three
National Center for Infants, Toddlers, and Families
734 15th Street, NW, 10th Floor
Washington, DC 20005
(202) 638-1144
Publications: (800) 899-4301
Fax: (202) 638-0851

APPENDIX C

The Head Start Mental Health-Related Performance Standards

Source: Federal Register, 45 CFR Part 1301 et al. Head Start Program Final Rule, November 5, 1996

Federal Register, Vol. 61, No. 215; Tuesday, November 5, 1996; Rules and Regulations; p. 57212.

1304.20 Child health and developmental services ....(b)

(b) *Developmental, sensory, and behavioral screening.* (1) In collaboration with each child's parent, and within 45 calendar days of the child's entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate developmental, sensory, and behavioral screenings of motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b)(3) for additional information). To the greatest extent possible, these screenings must be sensitive to the child's cultural background.

(2) Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs.

(3) Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior.

Federal Register, Vol. 61, No. 215; Tuesday, November 5, 1996; Rules and Regulations; p. 57216.

1304.24 Child mental health

(a) *Mental health services.* (1) Grantee and delegate agencies must work collaboratively with parents (see 45 CFR 1304.40(f) for issues related to parent education) by:

(i) Soliciting parental information, observations, and concerns about their child's mental health;

(ii) Sharing staff observations of their child and discussing and anticipating with parents their child's behavior and development, including separation and attachment issues;

(iii) Discussing and identifying with parents appropriate responses to their child's behaviors;

(iv) Discussing how to strengthen nurturing, supportive environments and relationships in the home and at the program;

(v) Helping parents to better understand mental health issues; and

(vi) Supporting parents' participation in any needed mental health interventions.

(2) Grantee and delegate agencies must secure the service of mental health professionals on schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health; and

(3) Mental health program services must include a regular schedule of on-site mental health consultation involving the mental health professional, program staff, and parents on how to:

(i) Design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children;

(ii) Promote children's mental wellness by providing group and individual staff and parent education on mental health issues;

(iii) Assist in providing special help for children with atypical behavior or development; and

(iv) Utilize other community mental health resources, as needed.

APPENDIX D

Program and Resource Contacts Cited in *Lessons from the Field*

Action for Boston Community Development (ABCD)
(ABCD is the grantee for all Boston Head Start programs)
178 Tremont Street
Boston, MA 02111
(617) 357-6000
Contacts: Marie Galvin, Director
Karen Tewhey, Mental Health Coordinator
Carolyn Boehne, Parent Involvement and Family Services Coordinator

The Center for Preventive Psychiatry
360 Mamaroneck Avenue
White Plains, NY 10605
(914) 949-2660
Contact: Paul Donahue, Ph.D.

Child and Adolescent Service Center, Head Start Site
1379 Garfield Avenue, SW
Canton, OH 44706
(330) 456-6218
Contact: Jeffrey D. Poulos, Preschool Community Services Coordinator

Child Development Resources of Ventura County Head Start
2500 Vineyard Avenue, Suite 200
Oxnard, CA 93030
(805) 485-7878
Contacts: Alicia Ramirez, Head Start Program Manager
Teresa Cole, Mental Health Consultant

Community Partnership for Child Development Head Start
2132 East Bijou
Colorado Springs, CO 80909
(719) 635-1536
Contacts: Terry Schwartz, Assistant Director
Rebecca Stocker, Family Services Coordinator
Dorothy Madre, Free to Grow Neighborhood Family Advocate

Economic Opportunity Commission of Nassau County Head Start
134 Jackson Street
Hempstead, NY 11550
(516) 292-9710
Contact: Jean Davis, Director

Family Development Specialist Initiative
National Resource Center for Family Centered Practice
The University of Iowa School of Social Work
112 North Hall
Iowa City, IA 52242-1223
(319) 335-2200
Contact: Sarah Nash, Marketing Director

Free to Grow
Columbia University School of Public Health
154 Haven Avenue, 2nd floor
New York, NY 10032
(212) 304-7136
Contact: Lori Santo, Deputy Director

Ft. George Community Enrichment Center Head Start
1525 St. Nicholas Avenue
New York, NY 10033
(212) 927-2210
Contact: Lenore Peay, Director

Hawkeye Area Community Action Program (HACAP) Head Start
P.O. Box 789
5560 6th Street, SW
Cedar Rapids, IA 52406
(319) 366-7631
Contacts: Chris Carmen, Director
Tammy Rynder, Family Support Counselor

Head Start Parent Involvement Project
Center for Population and Family Health
Columbia University School of Public Health
60 Haven Avenue
New York, NY 10032
(212) 304-5251
Contact: Faith Lamb Parker, Ph.D.

Jumpstart
93 Summer Street
Boston, MA 02110
(617) 542-JUMP
Contacts: Aaron Lieberman, Executive Director
Rebecca Weintraub, New Site Development Coordinator
Ana Vasquez, Education Coordinator

Lane County Head Start
221 B Street
Springfield, OR 97477
(541) 747-2425
Contact: Karen Hamilton, Education and Disabilities Coordinator

Lane County Head Start, Westmoreland Center
1717 City View
Eugene, OR 97402
(541) 344-4086
Contacts: Molly Hufford, Regional Manager
Robin Winfree, Teacher

Management and Prevention Program
School Psychology Program
College of Education
5208 University of Oregon
Eugene, OR 97403-5208
(541) 346-2143
Contact: Ruth Kaminski

New Haven Board of Education Head Start
54 Meadows Street
New Haven, CT 06510
(203) 946-8913
Contact: Ruth Turner, Director

North Shore Child and Family Guidance Center
Lindner Early Childhood Training Institute
480 Old Westbury Road
Roslyn Heights, NY 11577
(516) 626-1971
Contacts: Sandra Wolkoff and Tina Rotstein

Rainbow House Choosing Non-Violence
Rainbow House/Arco Iris
P.O. Box 29019
Chicago, IL 60629
(773) 521-5501
Contact: Anne Parry

Rosemount Head Start
2000 Rosemount Avenue, NW
Washington, DC 20010
(202) 265-9888
Contacts: Marta Gonzalez, Director
Joanne Fulford, Family Advocate and Home Visitor
Halcyone Bohen, Ph.D., Mental Health Consultant

St. Bernard's Head Start
51 Prospect Avenue
White Plains, NY 10606
(914) 949-6202
Contacts: Joyce Wachman, Director
Carol Belmont, Head Teacher, Therapeutic Classroom

Stark County Community Action Agency Head Start
402-2nd Street, SE
Canton, OH 44702
(330) 456-6218
Contacts: Bonnie Wheeler, Director
Pamela J. Vann, Special Needs/Mental Health Coordinator

Start Healthy, Stay Healthy
Center on Budget and Policy Priorities
777 North Capitol Street, NE, Suite 705
Washington, DC 20002
(202) 408-1080
Contacts: Donna Cohen Ross, Project Director

Staten Island Mental Health Head Start
44 Dongan Hills Avenue
Staten Island, NY 10306
(718) 987-7755
Contacts: Beryl Clark, Director
Susan Young, Assistant Director

Ulster County Head Start
70 Lindsley Avenue
Kingston, NY 12401
(914) 338-8750
Contacts: Pamela Wenner, Director
Aileen Jones, Family Services/Parent Involvement Coordinator
Judy Dagirmanjian, Mental Health Coordinator

Ulster County Mental Health
239 Golden Hill Lane
Kingston, NY 12401
(914) 340-4000
Contacts: Ernest Townsend, D.P.A., Director
Karen Meissler, Psy.D., Coordinator of Head Start Collaboration

Ventura County Mental Health
300 Hillmont Avenue
Ventura, CA 93003-1699
(805) 652-6737
Contacts: Donald Kingdon, Chief, Child and Adolescent Services
Craig Ichinose, Senior Research Psychologist

Western Community Action Head Start
P.O. Box 246
Marshall, MN 56258
(507) 537-1416
Contact: Beverly Wilson, Director

Edward Zigler Head Start Center
81 Olive Street
New Haven, CT 06511
(203) 946-8976
Contact: Marta Corniel, Teacher

Other Resource Centers:

Early Screening Project
Oregon Research Institute
1715 Franklin Boulevard
Eugene, OR 97403-1983
(541) 484-2123
Contact: Edward Feil, Ph.D., Research Associate

Partners Parent Training Curriculum
School of Nursing
University of Washington
Parenting Clinic
1107 NE 45th Street, Suite 405
Seattle, Washington, 98105-4631
(206) 543-6010
Contact: Carolyn Webster-Stratton, Ph.D.

Resiliency Partnership-Directed Intervention
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104-6216
(215) 898-4790
Fax: (215) 573-2115
Contact: John Fantuzzo, Ph.D.

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